MENTAL HYGIENE

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MENTAL HYGIENE IN THE EMERGENCY *

INTRODUCTION

ADOLF MEYER, M.D.

President, The National Committee for Mental Hygiene; Psychiatrist-In-Chief, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore; Henry Phipps Professor of Psychiatry and Director of Department of Psychiatry, Johns Hopkins University

IT is my privilege to welcome a gathering that wishes to hear the report of work done and the spirit of the work under way and the further work plans of The National Committee for Mental Hygiene.

There being apparently only two here, Dr. William L. Russell and I, of those who thirty-one years ago were present at the Committee's first gathering, I should like to speak also for Mr. Clifford W. Beers, to whom we owe this working together of professional and lay interests in the health of the human individual as person and in human relations.

There has never in the history of our organization been a time when the immensity of our problem could have aroused greater concern and offered a more vital opportunity for enthusiasm than this moment. The dice of fate are being rattled in the hands of a few personages, ready to cast what may determine a long-time fate of humanity. It is our duty and our opportunity here to make this more than a gamble of dice. With a telling record behind us, we are in the midst of work with obvious tasks, and we shall hear the voices of the workers in the cause, giving the perspectives and the plan for a "now and here," such as never before has been

* A symposium presented at the Thirty-first Annual Meeting of The National Committee for Mental Hygiene, New York City, November 14, 1940.

faced with equal necessities, or with equal opportunity to make ourselves effective. Fear can no longer throw the whole of intelligent humanity into a huddle of abject defeat.

To make for the health of personal functioning, the health of the person and of the group is our concern. Twenty-three years ago when a war was declared, our organization, through Dr. Salmon, rendered a great service in a crisis in which the health of an army was at stake. To-day it is much more than an army that concerns us. It is the sense of security of mankind that is at stake, and it is our share and our duty to contribute to the sanity and security of our *own people.* To-day we must offer far more than armament and man power—viz., a national core and a national front and the unity and planfulness and morale that can come only out of sound effort and determination. We must know where we stand and where we are going.

Let us hear first from the medical director, Dr. George S. Stevenson, who will give us his own report of the first year of his leadership. He assumed his new duties with a remarkable record of the largest and broadest effort ever made to bring mental hygiene to our parents and children. He gives us to-day what he inherited from his able predecessors and what has become possible during one of the most difficult periods in the sheer maintenance of the Committee. He brings to us sound experience. He represents the same quality in his present responsibility and opportunity.

I trust that this report and its recommendations make clear what we all are called upon to make possible and actual.[1]

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According to the plan of the Committee, it is my privilege to call on Dr. Edward A. Strecker, Professor of Psychiatry of the University of Pennsylvania, who is chairman of the Scientific Administration Committee. Dr. Strecker was last year's Thomas W. Salmon lecturer, and as the Director of the Institute for Mental Hygiene of the Pennsylvania Hospital, he holds one of the key positions in the practical professional work of psychiatry. To him I wish to pass the further direction of the meeting.

[1] Dr. Stevenson's report, which is omitted here, will be published as part of the annual report of The National Committee for Mental Hygiene.

MENTAL HYGIENE AND MASS MAN

EDWARD A. STRECKER, M.D.

Chairman, Scientific Administration Committee, The National Committee for Mental Hygiene; Professor of Psychiatry, University of Pennsylvania

WE are at a time in the history of our species when mankind has set its collective feet upon a most dangerous road. Already that road is red and slippery from the costly, and largely needless, spilling of human blood. Instead of the milestones that marked the fruitful centuries of artistic and scientific achievement, there is tangled débris from havoc and destruction. Instead of the shafts of bright light illuminating the upward struggle of man in the liberating of his spirit, there are barbaric "blackouts" of his liberties and the democratic brotherhood of his soul.

Down such a path men are marching in vast numbers, herded together like frightened sheep—marching with "wool rubbing wool" and heads down. But unlike sheep, they have fallen into the hands of false shepherds, and their wolves, disguised as sheep dogs, are herding the sheep for the kill. Fear is the handmaiden of bloody violence. Coldly and calculatingly evil men have unleashed in great masses of men archaic drives of murder and destruction which would have shamed Neanderthal man, who killed for utilitarian reasons.

The barriers that try to stem the descent to barbarism are few and pitifully weak. There are more mechanisms designed to accelerate the downward march than barriers to impede it.

Now we may see clearly the bar sinister across the Janus-like face of the shields of the ideologies of political movements—of so-called "social democracy," of totalitarianism, of Communism. In practice, each one of them seeks a merciless regimentation of the physical and mental efforts of man, a belittlement and enslavement of his spirit. In practice, they are malignant dictatorships.

The potential for good in propaganda is now indeed faint. Scarce may it be heard against the brazen blare of false propaganda; scarce may it be seen through the thick clouds of emotional incense with which the high priests of unscrupulous propaganda enshroud their rites. Technical science,

though it is the amazing achievement of our epoch, all but annihilating time and space and harnessing the forces of nature, has very considerably been turned to base purposes. Joad's statement, "The aëroplane was made by supermen, but has fallen into the hands of the apes," is all too sadly true of even the greatest technical discoveries.

Disputing the march against civilization and culture, there stand the humanitarian disciplines, and among these mental hygiene is best equipped to halt the march toward barbarism —equipped by psychiatry's many years of experience with mental patients. In mental patients there is the same debasement of intelligence, the same orgy of emotion, the same gross errors of judgment, the same resort to primitive behavior as there is in the mass movements of the day. Girded by the experiences of psychiatry, mental hygiene merely needs to lift its eyes from the single patient to the many—mobs on the march. Mental hygiene needs only to lengthen and broaden the perspectives of psychiatry. Mental hygiene is now ready to look "beyond the clinical frontiers."

Democracy, specifically the democracy of our United States, has two jobs to do.

The first may be unpleasant, but it is of the utmost importance. We must place the barricades of democracy squarely in the path of the formidable threats to our liberties. We must man those barricades effectively. No one can predict whether it will be sufficient to man them only by industry and its products or whether armed forces also will be needed. In any event, we do know that these barricades will be weak and vulnerable unless mental hygiene is permitted to use the methods of psychiatry in selecting the men in industry who will make the material that will go into the building of the barricades and the conditions under which the material is made. If need be—and pray God it need *not* be, but if need be—psychiatry must pass on the fitness of the men who may have to hold the fort of democracy by force of arms. And finally only mental hygiene can heal the wounds of mind and soul in soldier and civilian.

The second job looks toward the rainbow of the future—that future when democracy will no longer be imperiled; when it will want to consolidate its gains, the more dearly prized

because they will have been so hard won. Then, as now, mental hygiene will be sorely needed—needed to educate in humanitarian and spiritual terms, to teach less about the human products of the past and more about how to liberate human intelligence and sympathy.

And in the vanguard will be mental hygiene, freeing the spirit of men, "for the free spirit needs no crowds to keep up his faith. He is truly social, for he approaches his social relationships with intellectual discriminations. His judgments are his own. He contributes to the social not a copy or an imitation, not a childish wish fancy furtively disguised, but a psychic reality and a new creative energy. It is only in the fellowship of such spirits, whatever political or economic forms their associations may take, that we may expect to find the Republic of the Free."

PSYCHIATRY IN THE EMERGENCY

HARRY STACK SULLIVAN, M.D.

President, The William Alanson White Psychiatric Foundation, Washington, D. C.

THE ideal of mental health implies an adequate adjustment of personal requirements for satisfaction and sense of security to the permissive social structure and the community group in which the individual has his being. The emergency confronting this nation is in many ways unparalleled in the history of man. Its bearing on the mental health of the citizen is complex and in some ways baffling to those of us who must seek to protect our fellows from mental disorder.

The social order to which the American people are accustomed, from which every one of us has absorbed an important part of his personality, is itself threatened with dissolution. To the extent to which this prospect is vividly within our awareness, we see ourselves in danger of being plunged into a world so foreign to our personality organization that we shall be unable to survive in it. The immediate threat to the capitalistic-democratic social order arises from the dynamic totalitarian axis. This axis presents a terrible

threat in the shape of total war—in the economic and terror strategy of which we are already involved.

The totalitarian axis is not the ultimate source of the threat to which our social order is exposed. Behind the war now involving most of the earth is a world-revolutionary movement which requires change of velocity in capitalistic-democratic social systems if they are to survive. This is the most significant difference between the present situation and that which confronted us in 1914–1918.

It is obvious that living is essentially dynamic—that there is no static condition in the relations of living things and their necessary environments. There is this continuous change in the cultural environment of man. Institutions and ideas change. This change is opposed by conservative tendencies which are perhaps derived from our animal fear of the unknown. Be that as it may, the social organization of any healthy group of people shows progression and the mental health of those who make up the group is functionally dependent on the balance between the velocities of institutional change and human understanding.

If more and more people suffer thwartings and insecurity because of a lag in the development of the social organization in which they have their being, mental disorder becomes more and more characteristic of the denizens of that social order and, as a result, its disintegration and radical reorganization become inevitable.

The history of man indicates that vast achievements and precious values are endangered or destroyed in any crudely revolutionary change. There is never so much of human achievement and realization of the true and the beautiful that we can afford to spare any that can be protected from social upheaval. Certainly this is the case to-day. The most profound psychiatric problem of the present emergency is that of remedying the lag in our social evolution so that we shall escape destruction by the world-revolutionary current that is beating against everything that has been built up in the past 3,500 years.

The second most fundamental psychiatric problem that confronts us arises from the character of modern war as it has been evolved by Hitler, Goebbels, Goering, and other

embodiments of the destructive factors that have been accumulating in the Western culture. The totalitarian powers exist and grow chiefly by virtue of a loss of popular faith in what I shall call the divinity of man. The gods have always been projections on a universal stage of the highest hopes and aspirations of great leaders, and of their worst. With the coalescence of the peoples of the world into one community through the integrating functions of communications and commerce, there has gone a disintegration of old faiths. No world leader has appeared. The altruistic, ethical, and æsthetic foundations of civilization have crumbled, and only natural science has prospered. Because no leader has appeared to crystallize in the nobility of his statements a new formulation of the essential goodness of man, there has been a recession of altruism and a blunting of those ethical feelings which are the common man's substitute for an understanding of his interdependence with every one else. In this setting there has arisen evil leadership that degrades man completely and makes of him and of his scientific knowledge merely instruments of destruction and conquest. This is alike the matrix and the pattern of total war.

Psychiatry, the science concerned with interpersonal relations, sheds some faint light in this dark scene. I fear that psychiatry must accept the appalling responsibility of immediate leadership in an attempt to defeat the assault by terror and personal disintegration and the destructive utilization of all knowledge.

The next level of psychiatric problem is that of the various day-by-day performances that buttress the security of our nation and that help toward victory for the few remaining champions of human values. I speak here of the building up of our armed forces, of our military and naval machines and munitions, and of the basic solidarity and morale of our people.

For the double reason that we are creating a military reserve, the members of which will be on call for ten years after the completion of their training, and that no one can predict if and when we will be involved in combat operations, it is imperative that the quality and durability of military and naval personnel be as good as possible. This means the

exclusion of as many as may be of those who suffer mental and personality handicap. The Selective Service System has shown extraordinary foresight in this matter and is instructing local boards and their medical examiners in the rudiments of psychiatric diagnosis, together with directions to refer all dubious candidates to medical advisory boards for examination by qualified psychiatrists. Besides this double screening, the army is making unusually practical provisions for psychiatric examination of all candidates before induction, and for rigid psychiatric scrutiny at reception centers—if the medical corps can secure a sufficient number of psychiatrists. There is an acute need for a hundred younger psychiatrists to-day.

Besides armed forces, the national mobilization includes industry, the manufacture of machines and munitions of war, and the industrial psychiatric problems connected with a vast reëmployment program. Beyond all this is the improvement and protection of civilian solidarity and morale, the elevation of civic responsibility to the rôle of guiding principle everywhere, and the detection and neutralization of demoralizing and otherwise dangerous people.

Total war requires the integration of the whole people. The armed forces can be destroyed by the failure of national morale just as surely as by national economic disaster. The strategy of economic war as developed by the totalitarian group is already a serious threat to us, but a threat second in importance to that from the strategy of psychiatric warfare. We are face to face here with weapons with which, fortunately, psychiatrists have some ability to cope. I do not mean that psychiatrists can immediately evolve a counter-strategy with which to defeat the enemy strategy of terror. I mean simply that our acquaintance with human destructiveness and with the disintegration and disorganization of personality is invaluable equipment with which to attack the problems in this field.

Finally, the promotion and protection of civilian morale call for suppression of the unwitting or involuntary giving of aid and comfort to the enemy by persons who are suffering from mental defect or disorder. Always a problem in social evolution, this aspect of our population assumes new signifi-

cance because the per capita proportion of negative mental deviation will be increased by rejections from the armed and the industrial organizations, and as a direct effect of psychiatric warfare. Coupled with this, an increase in the load of all psychiatric personnel cannot be avoided because institutional and clinic staffs will have to supply most of the psychiatrists needed in the other aspects of national mobilization. All these facts and many more demand immediate consideration.

The archaic beliefs about mental and personality peculiarities and disabilities that are still entertained by the public assume new importance as obstacles to the promotion of public mental health. Consider, for example, the case of a workman rejected by the Selective Service System because of mental or personality handicap. The mother of another registrant wants to know how this has come about; this Tom did the same work and earned the same wages as her Jerry, who is now at camp. How do you account for this, if there isn't discrimination? Suppose that the local-board authorities, in self-defense, explain that Tom is mentally unsuited to the service requirements. How will this explanation be taken by Jerry's mother? How will neighborhood gossip about it affect Tom's mental health?

Consider the parallel resistances to psychiatric assistance that will appear at many points in the industrial mobilization.

Consider the related difficulties that will be encountered in every community when we try to utilize psychiatric insight in protecting and promoting civilian morale.

The potentialities for evil that lie in public ignorance and superstition about personality factors at this juncture become truly appalling when we add to our consideration the limited results of efforts already made for their remedy. The National Committee for Mental Hygiene has been active in this connection for more than twenty years. The returns, while gratifying, do not suffice us now. We must review our experience, seek out the factors that are most obstructive, and develop methods to neutralize, when we cannot remedy, the evil consequences of this lag in social intelligence—*i.e.*, in our civilization.

In this last, as in all the other phases of our problem, the general medical man may well be the focus of concerted

psychiatric effort. He must be utilized in the preliminary psychiatric work of the Selective Service System. In his rôle of industrial physician, he may do a great deal to solve the problem of effective psychiatric assistance in the industrial mobilization. He should be made effective in the protection and promotion of civilian morale. He is the first that we should consider of the culture carriers who conserve the archaic traditions about psychiatric matters. We may well review our experiences in the psychiatric education of the practicing physician, and learn what we can from successes *and* failures.

In brief, psychiatry is obviously in an utter emergency. If psychiatrists are to meet the challenge, they must show an unparalleled readiness for organization, and most extraordinary personal energy and application in accomplishing tasks for which they lack practical experience. The fundamental competence exists. The staff work of mobilizing psychiatry is begun. The refining of basic theory and practice is proceeding. The devotedness, self-sacrifice, and tremendous energy that will be required may, I trust, be expected to appear.

I say to you that psychiatry has suddenly found itself confronted with a stupendous opportunity for services vital to the protection of the very social system that finally evolved modern psychiatry itself. There is not one psychiatrist who can be spared from the national mobilization. Our tasks will not be done unless every one of us works as he has never worked before in a collaboration that will itself be the triumph of psychiatric principles over the defects to which our time is heir.

WAR WORK IN CANADA

CLARENCE M. HINCKS, M.D.

General Director, The National Committee for Mental Hygiene (Canada)

CANADA'S war effort has involved the military enlistment of 323,000 men, the employment of all available skilled man power for the manufacture of munitions and supplies, and the voluntary participation of practically every citizen in some form of war work.

While fatalities among the Canadian armed forces have been few, and the general health of the troops good, mental and nervous disorders have been prominent among the disabilities that have developed—accounting for more than 1,000 cases, of which 156 were major psychoses. It is interesting to note that 16 per cent of the men who have recently been invalided home from Britain have been afflicted with these disabilities, and an additional 26.5 per cent had duodenal ulcer —a condition so frequently associated with emotional disturbance and tensions.

A consulting neuropsychiatrist has been appointed to the Canadian Army Medical Corps, and there has been organized a neurological hospital for Canadian soldiers in Britain, but to date no psychiatrists have received military appointments to serve as psychiatrists on examining boards or with hospital units. This situation is somewhat alleviated by the fact that cases of mental and nervous disorders that require treatment can be referred to hospital centers maintained by the Department of Pensions and National Health and to civilian provincial mental hospitals.

Under existing arrangements, unless regimental medical officers are psychiatrically trained and keenly interested in the individual welfare of their men, there is delay in psychiatric diagnosis, delay in instituting prompt treatment when such is indicated, and neglect of preventive mental-hygiene activities involving counseling, the giving of morale and mental-hygiene talks to officers and men, and the paying of attention to controllable factors that mitigate against wholesome adjustment.

To assist in the identification and rejection of the unfit, one provincial mental-hospital system has prepared a list of 15,000 men of military age who have had psychoses, and has made this list available to military examining boards, with beneficial results.

Psychological testing is not a routine procedure, except in connection with one division of the air force, but it is available to other branches of the service upon the request of commanding officers.

Psychiatric research is included in the studies of the Division of Medical Aviation Research. Relationships between

shallow breathing and emotional instability are being investigated, and electro-encephalography has been useful in detecting individuals who have never had epileptic seizures, but who have convulsions under conditions of low pressure, similar to those of high flying.

The most significant preventive mental-hygiene work affecting the military forces in Canada has been the pooling of the efforts of more than 1,000 educational and welfare agencies throughout the dominion by the Division of Auxiliary Services of the Department of National Defense, to meet the educational, recreational, social, and counseling needs of enlisted men. Through opportunities for cultural growth, for the acquisition of varied skills, for social development, and for the attainment of robust mental and physical health, it is hoped to develop a fine democratic citizens' army that will be effective, not only in war, but in the tasks of peace that lie ahead.

A word in reference to the morale and to the general level of the mental health of our Canadian people as a whole. We are remarkably free from feelings of anxiety, apprehension, or defeatism. The war of nerves has made few inroads upon us. This has been due in part to the fostering of confidence and the will to win on the part of the press, the radio, the screen, and the church, and in part to the circumstance that everybody is working in the common cause. This constitutes effective occupational therapy in diverting attention from the tragedies and uncertainties of the war itself, and in strengthening morale. Of prime importance in influencing the attitude of Canadians has been the thrilling example of courage, determination, and self-sacrifice on the part of our compatriots in Britain—an example that we desire wholeheartedly to emulate—an example that inspires us to sustain at all costs our dauntless mother country. And because you in the United States have furnished Britain with such magnificent assistance, we, in Canada, love you for it, and feel closer to you than at any time in our history.

The National Committee for Mental Hygiene in Canada is discovering opportunities for service in collaborating in the mental-hygiene training of military medical officers; in encouraging the development of more adequate diagnostic,

therapeutic, and preventive progress affecting the military forces; and in conducting continuous surveys of our mental-hygiene facilities to assist in the maintenance of scientific standards that are threatened during the war period because of the increasing overcrowding of our mental hospitals and the depletion of psychiatric staffs through military enlistment. Other activities include the fostering of stamina and mental health among our young people and the stimulation of research.

May I close by quoting a recent public utterance of our Governor-General? He said: "Whatever may be the ill effects of the war on the physical well-being of our citizens, I feel sure that the most widespread havoc will be wrought in their nervous systems. The restoration of sanity to a shattered and unsettled world will be one of our most difficult tasks. There is urgent demand, therefore, for research in connection with the various afflictions of the mind."

I leave these words of the Earl of Athlone with you.

PSYCHIATRIC ASPECTS OF THE NATIONAL DEFENSE PROGRAM

HARRY A. STECKEL, M.D.

Chairman, Military Mobilization Committee, American Psychiatric Association; Director, Syracuse Psychopathic Hospital, Syracuse, New York

AT the Annual Meeting of the American Psychiatric Association in Chicago in May, 1939, upon a resolution by the council, the president of the association was authorized and directed to appoint a new committee, to be known as the Military Mobilization Committee, to be devoted to preparation for possible coming emergencies and to confer with other services as to needs and as to availability of personnel. The committee comprised the following: Dr. Francis H. Sleeper, Boston, Massachusetts; Dr. Appleton H. Pierce, Coatesville, Pennsylvania; Dr. Walter J. Otis, New Orleans, Louisiana; Dr. Samuel W. Hamilton, Washington, D. C.; and Dr. Harry A. Steckel, Syracuse, New York.

In order to determine what the needs are, arrangements

were made for a conference with representatives of the surgeons-general of the army, the navy, and the public-health service, which conference was held in Washington on October 16, 1939. These representatives agreed that the association could be of great assistance to them in case of a national emergency and expressed themselves as very happy to coöperate in working out any plan of procedure that we might suggest.

One of the first requests made of our committee by the armed forces was to formulate a brief psychiatric examination, to consume not more than fifteen minutes, which might be utilized in eliminating psychiatric risks. While we felt this a most difficult undertaking and perhaps almost an unfair request, we nevertheless, after consultation with the members of our committee and other interested persons, did submit such a short form, a copy of which was published as a portion of the report of the committee to the association, which appeared in the September, 1940, issue of the *American Journal of Psychiatry.*

The estimated needs of the armed forces were also discussed. It was found that the navy would require a minimum of one hundred and fifty experienced psychiatrists, while the army would require at least one psychiatrist to every five thousand troops—that is, on a minimum effort of a one-million-troop army, two hundred psychiatrists would be required—and that there were comparatively few well-trained psychiatrists already in the army.

It was, therefore, agreed that the first step would be a survey of the existing trained psychiatrists available for either of the services, and the preparation of a card index at the central office was undertaken, indicating many factors with reference to this available psychiatric personnel, such as age, availability for duty in one or the other of the services, and possible physical disability which might exclude the individual from active duty with the armed forces without disqualifying him for service in the home areas. A questionnaire was, therefore, prepared and approved by the army and the navy, and sent to all members of the association, as well as to all non-members who were listed by the American Medical Association as specializing in psychiatry or neurology.

As a result of this survey, it was found that for home service there were available 451 members and 255 non-members, while for the armed forces there were a total of 537 members and 306 non-members. However, a number of those indicated as available for the armed forces were already commissioned reserve officers, either in the army or the navy, or held positions in the National Guard, which reduced this number by about three hundred. It would, therefore, appear that there would be an ample supply of trained psychiatrists available for a maximum effort of an army of four million men.

These figures were, of course, reported to the surgeons-general, and while it was suggested that perhaps it might be well to organize several hospital groups for the care of psychiatric cases, this was not deemed advisable nor was the suggestion that we organize our groups by corps areas felt essential.

Very little further progress was made by the committee for a number of months, but in order that there might be more free discussion of the problems, a round table on military mobilization was included in the program of the annual meeting of the association, held in May, 1940, to which were invited representatives of the surgeons-general of the army, the navy, and the public-health service, and an interesting and instructive evening of discussion resulted.

One of the outstanding needs emphasized at the round-table discussion was the elimination, so far as might be humanly possible, of psychiatric risks in any recruiting program. How this might best be done became a concern of the committee. It was learned that some interesting experimental work with psychological and psychiatric screening was being done with reference to the recruiting of aviators for the Canadian Army, so the chairman of the committee, in September, 1940, spent several days in Canada and through the courtesy of Dr. George H. Stevenson, president of the association, was permitted to visit many of the training centers as well as the military hospitals, and some valuable information was obtained in this way.

The work of Professor Bott, of the University of Toronto, under the guidance of Sir Frederick Banting, was quite impressive, especially in that he had worked out a plan for

securing anamnestic data on a group basis. It is felt that this is one of the most difficult problems encountered in attempting to screen psychiatric risks in recruiting, as it is difficult in a short period of time to obtain a good family and personal history, yet with this group method it might be done. While the plan worked out quite satisfactorily in Canada, it was purely on an experimental basis and it has not been approved by the Canadian Army to be generally utilized. No special provision has been made by the Canadian forces for division, army, and corps psychiatrists. In this respect our own set-up is very much more satisfactory.

Upon the passage of the Selective Service Act, further overtures were made through correspondence by our committee with the offices of the surgeons-general, with little result. Other interested groups, including the William Alanson White Psychiatric Foundation, made contacts of various kinds, attempting to stimulate the interest of the Selective Service System in some method of screening the recruits. The main objections to any attempt along these lines seemed to be the time element and also the question as to whether or not sufficient well-trained psychiatrists were available, even if some intensive effort should be tried.

However, a conference was held at the offices of the Selective Service System, attended by Director Dykstra and several of his assistants, the chairman of the civilian advisory committee of the Selective Service System, representatives of the surgeon-general of the army and of the general staff, the president of the William Alanson White Psychiatric Foundation, and the chairman of the Military Mobilization Committee.

By virtue of the survey that we had already made of all available psychiatrists and the card index, which was now completed, we were able to show that while there might not be sufficient psychiatrists of army age available for active army duty, there were many available for so-called home service who could be utilized on a civilian basis at the induction centers, and that it is quite possible at these induction centers to allow sufficient time for psychiatrists to survey the recruits, so that many risks might be eliminated at this

point. A brochure was also submitted by the William Alanson White Foundation which will cover some of the outstanding points to be investigated in such a survey, and agreement was finally reached that one psychiatrist for every fifty men per day to be examined should be made a required complement of the medical forces at the induction centers. This, we feel, represents a real concession and should prove of invaluable service in eliminating undesirable recruits.

Our committee has been fortunate in having many members of the association interested in our work, and they have been helpful in many ways. Unfortunately, they are so numerous that one cannot give them all due credit at this time, but we feel that Dr. Winfred Overholser, because of his intimate contact with the authorities in Washington and his active interest in the problem, has been of unusual assistance to us. We are also grateful to the William Alanson White Psychiatric Foundation and its president, Dr. Harry Stack Sullivan, for his interest and help.

As the work has progressed, as is true of every psychiatric or mental-hygiene project, we get into an ever-widening field of activities, and the scope of the work of the committee has grown to be almost formidable. For instance, the matter of short refresher courses for psychiatrists involved in recruiting and induction centers was suggested by Director Dykstra as a possible aid, and perhaps this matter would best be handled by the association's Committee on Psychiatric Education. The matter of civilian morale and national solidarity has been repeatedly brought up by Dr. Sullivan and his group. Perhaps this should be a concern of the Committee on Public Education. The chairman of the Military Mobilization Committee has been invited to attend the meetings of the Division of Anthropology and Psychology of the National Research Council for a consideration of the problems of morale and has also recently been appointed to the Committee on Neuropsychiatry of the National Research Council.

This indicates the many ramifications that are involved in psychiatry and the defense program and the multiplicity of problems that have been deposited in the lap of the Mobilization Committee. While we are happy, within our natural

limitation, to assume these varied responsibilities, we feel that perhaps a division of labor should be in order soon, so that our efforts may not be spread too thinly over a wide field, but rather concentrated on the military-mobilization situation alone.

MENTAL GROWTH THROUGH EDUCATION

HARRY A. WANN, PH.D.
Superintendent of Schools, Morris County, New Jersey

EVEN a casual comparison of the better American schools of 1940 with the schools of a generation ago will reveal the striking changes that have come about in this brief period. The purpose of the school originally was to make children literate. The three "R's" characterized the curriculum. The acquisition of knowledge was the end of education. The function of the school was to develop the intellect. While this conception of education still prevails too generally in our schools, the trend is toward a type of school that sets its goal far beyond the acquisition of facts.

The mental-hygiene movement has challenged education to new purposes. Leaders in mental hygiene have led educators to see that schools must be concerned not only with intellectual development, but with the whole of life. The child does not bring simply his mind to the classroom to be trained in subject matter and factual information; with his mind comes a body, with all of its physical needs, a complex of emotions and natural drives, a pattern of habits and attitudes, the whole of which and all the parts of which must be the concern of education. It then becomes the task of the school to help the individual to grow not only intellectually, but physically, emotionally, and socially in a manner and to a degree that will be personally satisfying to the individual, and at the same time socially acceptable.

The psychologist has helped the educator to a better understanding of the intellectual processes, but it has remained for the mental hygienist to reveal and to interpret the emotional and social implications of the educative process. The remark-

able developments that have taken place in physical health began with the study of disease and its treatment. Research reached back into causes, and eventually the predominant purpose of medicine has come to be not only the prevention of disease, but the development of positive, robust, virile health. Likewise, in its early stages, mental hygiene was concerned with the atypical. Studies of mental diseases, personal and social maladjustments, and aberrations of exceptional cases have led through the various stages of treatment to a study of genesis and, eventually, to prevention. And, as was the case with medicine, mental hygiene is now endeavoring not only to prevent mental disease and personal and social disintegration, but also to discover ways and means of developing in each individual a well-integrated personality, which can face reality with courage, with zest, and with success.

Modern educators are accepting the challenge of this new discipline and are attempting to reorganize the schools to implement these new purposes. Case studies of delinquents, criminals, and the mentally diseased uniformly reveal the continuity of the stream of cause and effect. That "the child is father of the man" is more than a merely poetic statement. Adolescent and adult behavior has its roots deep in early childhood. The teacher, the parent, and others dealing with the child must not only see him for what he is—they must see him for what he will become.

A critical examination of the products of the school helps educators to recognize their problems and obligations. The graduates of the schools fill positions of honor and importance in state, in business and industry, and in the professions. The products of the schools also fill the jails, the courts, penal institutions, correctional schools, and hospitals for the mentally diseased. The cost of crime and delinquency is a tremendous drain on our national and human resources. More than half of the beds in the hospitals in our country are occupied by patients with mental diseases. At the present rate of mental breakdown, more of our school children will eventually enter hospitals for the insane and for the mentally diseased than will enter our colleges and universities. If we are not to squander a large share of our wealth and a dispro-

portionate amount of our energies in an attempt to rehabilitate pathological humanity, we must turn our attention increasingly to effective means of prevention and to the development of wholesome, well-adjusted individuals.

Since one out of every four of our population in America is in the schools and, since the schools deal with individuals in the formative years, the schools at once become our greatest challenge and our greatest hope. Many of our modern schools are creating a happy and attractive environment for children. Fixed routine, prescribed content of curricula and courses of study, final examinations, grades, marks and promotion, classes and regimentation, strict discipline, drab surroundings, and frustrated, unhappy, maladjusted teachers are giving way before a new concept of education. The child as a person has become the center of interest. Instead of judging them by adult standards and punishing or rewarding them in the light of these standards, an understanding teacher, who likes children, guides them in their development through experiences that are interesting, meaningful, and challenging.

The modern school realizes that education is not confined to the four walls of the schoolroom, but may be best described in the words placed by Tennyson in the mouth of the great Ulysses, on his return from his wanderings: "I am a part of all that I have met." Education and schooling are not synonymous. Education is the total of one's reactions to all of one's experiences; so the modern school is concerned with the child not only as a student in the school, but as a member of a family, a neighborhood, and a community, exposed to all the influences of his environment. The teacher and the school attempt to work with the entire social milieu that impinges on the life of the child.

I am attempting to describe a situation that has been realized in a few communities and that is being increasingly recognized by educators as the future of education. We are concerned, however, not only with a description of conditions as they now exist, but also with trends and directions. There are relatively few school systems that have available all of the scientific aids in medicine and in mental hygiene that are necessary for a good program of education. Only occasionally is a teacher-training institution primarily concerned with the personality of the students it trains as future teachers

in our schools. Scholarship still is the chief criterion of entrance to teacher-training institutions and the basis of selection of teachers in our school systems, with the result that scores of classrooms are occupied by teachers who are maladjusted, emotionally unstable, and, in many cases, definitely psychotic. Perhaps eventually we shall discover that mental disease is contagious and shall quarantine neurotic and psychotic school-teachers as we would those with measles or small-pox, instead of confining them in classrooms with impressionable children.

The training program for teachers should include courses in mental hygiene, psychiatry, and social-case-work techniques, such as are now part of the training of social case-workers. The selection of students for training schools should be based not alone and not primarily on scholarship, but should consider of prime importance personality, emotional stability, and social adjustment. One goal of the mental-hygiene movement in America should be to place on the staff of every school a mental hygienist in the person of a visiting teacher trained as a psychiatric social worker. There should also be available a mental-hygiene clinic or a child-guidance bureau, which would serve not only the schools, but the group-work agencies as well. Mental health should be considered at least as important as physical health.

The defense of our nation requires guns, battleships, planes, and other materials of war, but it also requires men. The equivalent of the cost of one or two battleships might well be devoted to a program of mental health for our boys and girls as part of our national defense program. The stress of this hour demands spiritual dynamics. This crisis is a crucial test of the mental health of our nation.

The National Committee for Mental Hygiene, during its three decades of service, has made a remarkable contribution to education. Its fourth decade might well direct its efforts toward consolidating and coördinating the interests in mental health in every state and community in our land, bringing together educators, social workers, doctors, psychiatrists, psychologists, and all individuals and groups interested in mental health, to implement a vital program of mental health in all the schools of our nation.

THE FAMILY IN OUR CHANGING WORLD

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WHEN friends meet, the first question after "Well, how are you?" usually is, "And how's the family?" Socially speaking, we are told that the family is not too good these days. It has been suffering from the three D's, desertion, divorce, and depression, and from an even more complicated condition known as social change.

The family is not what it used to be. The old patriarchal household was self-contained and self-sufficient, producing its own goods, protecting and educating its members, and providing its own forms of recreation. In modern times these functions have been largely taken over by industry, the school, the state, and other institutions. As the complete dependence of the individual upon the family has lessened, its authority over him has weakened. The increase in separations and divorces is seen as a symptom of these weakening ties.

Upon the heels of these changes came the depression. The report of the recent White House Conference on Children in a Democracy showed that from one-half to two-thirds of the children in America live in homes with an income of less than $1,260 per annum for a family of four. Without the wherewithal for decent housing, adequate food and clothing, and medical attention, family life is seriously impaired, nor can a home bring forth its finest fruits from a relief budget.

Economic problems bring other problems, as social workers well know. The father who loses his job is no longer the great provider and respected head of the house, but somebody who idly hangs around more or less in the way. Think what that does to him in the eyes of his children and in his own estimation. It is still worse if his wife or an older child becomes the breadwinner in his place. The impact of the youth problem, too, has borne heavily upon the family—the terrific frustration of young people thwarted in putting their energies to work, in earning a living, in marrying and establishing homes of their own. Fear, worry, irritation, distrust,

discord springing from adversity rather than perversity, can put a devastating blight upon family life.

A disturbing picture, all in all. Is a kind of devolution operating here, a reversion to the point where the family will become a more or less passing union for biological reproduction only? That would be an ideal solution if we wish to follow the totalitarian way of life. For an imposed form of government, in its need to regiment the individual, puts no trust in the family as a social instrument. To learn how to behave and how to think, the individual, if he is to serve the purposes of the totalitarian state, must be weaned from the family at a tender age.

In our form of government and of society, we have put our trust in the family. We have given it freedom to be itself, to develop its own life. The foundation of American democracy has been the free American family.

There is a toughness of fiber in the American family. The amazing thing is the way in which families have managed to maintain their character and integrity despite adverse circumstances. A study of older children by the American Youth Commission, showing how largely they were standing by their families, concluded: "Between their expressed satisfaction with the parental home and their apparent enthusiasm for homes of their own, the continued existence of the family as the fundamental social unit seems reasonably well assured." Nevertheless, economic security sufficient to permit a reasonable standard of living must be recognized and worked for as an indispensable requisite to the continued well-being and vitality of the American home.

The family has been changing in form throughout the course of history. Adaptation to social change is a necessity for survival, a sign of vitality. They recently dug up in Egypt an ancient papyrus which read: "Times are not what they used to be. Children no longer obey their parents. Everybody wants to write a book."

While it has relinquished functions that have lessened its status and authority, the modern family, stripped to its essentials, holds the possibility of being a finer and more socially powerful group. The home that is not also a factory, for example, may serve all the better as a home. The modern

family's potency, arising from the intimacy of its human relations, lies in its incomparable influence, for better or for worse, upon the personalities of its members. There is no substitute for the family in giving the individual the satisfactions he needs.

The family embraces the individual in a common whole of group interest with a closeness that no other group will ever approach. It holds him in almost exclusive possession during those formative years when the deep basic traits of personality are being molded—molded by the give-and-take of relationships within this close circle.

How can the individual be expected to have confidence and security in his relations with his fellows in the larger world unless his trust in others within the family is fulfilled? Here, if ever, the social nature and ideals of the individual must be nurtured.

The happy, well-adjusted home is most likely to produce children capable in turn of establishing happy, well-adjusted homes. We all know of many fine examples of the modern family in which positive forces replace negative controls. Instead of outright dictation of conduct, there is sufficient freedom of choice to enable the child to profit by experience and to encourage self-reliance. In place of stern authority, there is companionship between parents and children. There is confidence and frankness, and, as children grow older, a sharing in family counsels. Although the ties between husband and wife are more frequently severed than in the past, those that endure may be all the stauncher and deeper and result in finer parenthood.

Mobility, ease of communication, the growing number and importance of social undertakings, all demand that the individual be fitted for a wider and more intensive social life. The virtues that are needed for democratic life and citizenship to-day are those that grow out of the modern family at its best: emotional maturity; the ability and courage to be one's self, coupled with regard for the rights of others; the capability in the light of accepted individual differences of working loyally with others for common social objectives.

The meaning is clear. If democracy is to be strengthened, we must sedulously cultivate the family.

Hand in hand with efforts to improve the health and economic well-being of the family, should it not be the chief business of the community to improve family life itself—the stuff of which the family relationships are made and out of which the individual grows? For the family is not a static institution, but a dynamic process, the most powerful force at our command for the promotion of mental health. Knowing that there are scientific aids to living, people are more and more unwilling these days to endure removable personal and social handicaps. The demand for family counseling and for education in marriage and the family is growing apace. This demand will be met in some fashion. Our concern must be that it is met by those fully qualified, if we are not to miss the supreme opportunity for preventive and constructive mental hygiene. This calls for the fullest coöperation of medicine, psychiatry, the church, education, social case-work, and other agencies in both research and practice.

In keeping with the general trend of social change, the family, too, is changing, and I believe for the better. But the chief goal of our efforts to build democracy and to liberate the individual is unchanging. It remains in the family.

THE WARP AND WOOF OF MENTAL HYGIENE

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WHAT you have heard in the preceding papers is really the warp and woof of mental hygiene, so that what I add can be no more than a sort of restatement. The shuttle races back and forth, and no one here—least of all, I myself—can predict the pattern. Yet unless we can outline at least the general characteristics of that pattern, we are shirking the responsibility that this fourth decade of the Committee's life thrusts upon us. For thirty years there has been a brilliant meeting of the needs of situations as they arose. Will our next decade under new leadership be of the same nature, or may we somewhat more definitely trace its course in advance? The shuttle will weave in the details, but I believe

that with some assurance we can describe the warp—the threads upon which that pattern will unfold.

First, these are the first times in the course of history when human adjustment and human behavior are seen as attempts at solving problems. From the pranks of the veriest youngster to the deepest dementia of the back wards we are realizing that problem people are really people who are trying to solve problems rather than to create them. It is easy enough, for instance, to realize that here at my right sits a man, Dr. Adolf Meyer, who in great simplicity has led us in this search for understanding. But it is very difficult for us to realize that his life practically spans any such approach to the problems of behavior. This whole matter of seeing what people do as an effort on their part to solve problems, is essentially new. The first thread of our warp is that we try to understand conduct instead of being irritated by it.

As to this first thread, may I make two remarks. Our search and research in this field will be slow; our impatience over progress often smacks dangerously of the childish immaturity that we so roundly denounce in our clients. Then may I point out that we who believe that we can unravel the tangled threads of the behavior of our most disturbed patients are disloyal to our profession if, in looking out on the world to-day, we simply shout, "Mad dog!"

From the warm cuddling of the smallest baby to whatever strident terror sweeps over continents, we must attempt to *understand.*

Second, we live in a time when "action at a distance" has a new meaning. There was a time when each human being's world was bounded by his teeth, his talons, and the length of his legs. Then one day some one threw a stone. This enlarged man's world—twenty yards or perhaps a bit more. We know that it took many thousands of years for man to adjust to this tiny enlargement of his sphere of influence. And we can guess that in that time there was every sort of disturbing problem of personality adjustment. "Action at a distance" has not changed much down through the ages to our own times. But now the automobile, the telephone, the aëroplane, the radio—all these have tremendously enlarged the world of each of us, and brought a hemisphere crashing about our ears. The telephone company tells us

that we can talk halfway round the world if we have anything to say.

But we haven't anything to say.

Fear, anxiety, increased nationalism, sharpened intolerance—these and other emotions of their ilk are the price we pay, and will continue to pay. Are we so niggardly that we will not pay for growth? I'm not saying that I *like* the world picture of to-day any better than you do—but that isn't the point.

As man struggles to new levels of adjustment, we must give *reassurance* as to what are the real things that are happening—that "action at a distance" is to have a new meaning undreamt of by those before our generations.

Third, this is the first time in the last six hundred years when there is beginning to be a change in balance between emphasis on the intellectual and emphasis on the emotional aspects of life. I realize that even before the first printing of books people were interested in the written word. But certainly since that time there has been an overweening emphasis on our dependence upon books, words, techniques—all of those things that can be printed. Now even the deepest, the most subtle, the most archaic of man's relationships are to be subjected to numbers, to verbalization, to techniques. What one means by "the turning point" is that we are beginning, in our generation, to remember that the emotional, the visceral, represents the older, the deeper, the more body-embracing part of our make-up. Real steps so far have been taken by certain leaders in the field of education, and the rest of us must give full support here. You will understand, as I do, that one can't really take people apart, separate them into intellectual and emotional fractions—yet you will also understand, from the sort of thing that Dr. Wann talked about, that we are beginning once more to recognize the deep importance and language value of feelings, drives, attitudes, yearnings. That this is a return to a former balance doesn't prevent our myopic gaze from seeing it, for our times, as another essentially new problem of adjustment.

So to understanding and reassurance we add the thread of *a proper balance between the intellectual and the emotional*—between words and psycho-motor tensions—between techniques and attitudes.

Fourth, we live in a day when man for the first time seeks the democratization of values. This is, up to now, man's highest venture. No one knows—no one can even guess—how it will come out, whether in magnificent triumph or complete disaster. But we are on the high road and we cannot turn back.

Nine hundred years ago the common man began taking the forms of government into his own hands. It is no matter of chance that there were then a hundred years of the same anxiety, fear, economic disturbance that we see to-day. During the Renaissance the common man began to assert his knowledge of and control over the material world about him—and with the birth of science came once more many generations of questioning, of fear for the future, of dislocation of all that had seemed fixed. And now for three generations the common man has once more ventured into new fields of control. As once he tore away at the imposing structure of imposed government, as once more he began to snatch away the veils of mystery that covered his material world, so now he challenges the ability of the various parts of his institutional structure to give him his values. What is it all about? What is worth while? These questions now for the first time man would fain answer for himself. As has been said, "it is not now so much that John find a job as that John find himself."

I doubt that it is the task of our Committee to pass judgment on this development. Here it is as man's next great venture. Perhaps it comes too soon; perhaps it is beyond our moral stature. With certainty we can predict many generations of anxious questioning; with certainty there will be many a timorous retracing of steps back to authoritarian set-ups which so comfortably fix our values for us. A psychiatrist would expect that there will be these resurging waves in this country just as there have been abroad.

Yet we are disloyal to our profession if we cannot see, beneath these terrible surface phenomena of brazen demand and frightened timidity, the adventure toward which man has set his face. And we are disloyal if we do not stand by with counsels of *courage* and *faith*.

The shuttle weaves the weft and we cannot predict the pattern. But the threads upon which it is to be woven—can

we not, must we not, know these if we are to go into our fourth decade adequate to the trust that is being put in us?

And may I say four things about these four threads of the warp—the threads of understanding, of reassurance, of a proper balance of the elements of the personality, of faith in man's venture?

1. Many of you would add a fifth thread—and call it guidance. With this I would have no serious quarrel—particularly as we would probably find that we are far from unified in our definition of this word "guidance." Our clinical experience is that each year we become more conservative about setting values for others. We feel more and more that our function is to clarify the issues as best we can—that the choice between them lies in the hand of the patient. It is in this sense that I personally feel that guidance is not one of the threads of our warp.

2. These four threads are all in Clifford Beers's book. There, as to-day, the shuttle fills in certain idiomatic details, but there is nowhere that that great document goes beyond its poignant plea for understanding, for reassurance, for a righted relationship between the demands of the various elements of the personality, and for courage and faith in the future.

3. As I talk, hundreds of psychiatrists up and down this country are giving succor to confused and lonely persons. These same four threads are the warp of each of these patterns.

4. This is a corollary of the two preceding statements—in the sense that what we have discussed to-day is but a larger picture of what I think of as the best of mental hygiene in its individual application.

As The National Committee for Mental Hygiene enters its fourth decade, it must be with a growing realization of the warp upon which the total pattern is developing. Those five threads that I have discussed you may, individually, retain or reject. That isn't the important thing. What does count is that in some such manner we do our best to understand the threads of the warp.

Then it is that we ourselves can go forward with courage and faith—no matter with what crazy speed the shuttle darts back and forth.

THE CLERGY AND COMMUNITY EDUCATION FOR MENTAL HYGIENE

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THAT there is a profound need for education of the average citizen along the lines of mental health, including both the principles of mental hygiene and the aims and functions of mental-hygiene agencies, hardly calls for argument. After the value and the effectiveness of the purely individual approach to mental hygiene have been accepted, there still remains, as Plant and others have pointed out, a great task that can be approached only on a group basis. The therapist in his consulting room may assist an individual to change his attitude toward a given cultural pattern, and to find some less threatening relationship to it, but he can do little toward changing cultural patterns that need changing. This requires the utilization of techniques operating on a group scale, a procedure that, in the interests of mental health, should no longer be neglected.

That such community education cannot be carried on solely by psychiatrists and mental hygienists is also obvious. Various public agencies and institutions must function in this work in coöperation with mental hygienists. It is the purpose of this paper to discuss the function and responsibility of the church (as one among other agencies) in the task of community education for mental health. Naturally such a discussion will lead into a consideration of the responsibilities of the clergyman as the professional leader of the church.

Why should the church interest itself in education for mental health? Does such an interest take it outside of its legitimate realm? There are those, both inside and outside of the church, who would answer this question in the affirmative, and who would insist that the church confine its efforts to the teaching of "religion." If, however, we ask ourselves what teaching religion means, we discover that it means teaching a way of life. All vital religious teaching involves

not only beliefs and attitudes about life and the universe, but also, either by implication or definite precept, a code of behavior. Whatever concept a man may hold in regard to God, that concept involves a way of life.

Beliefs, attitudes, and behavior are very important also from the point of view of mental health. In fact, health is one criterion—and one the importance and implications of which religion has tended to neglect—by which to judge beliefs, attitudes, and behavior. Religious beliefs and attitudes affect mental health for better or for worse, depending upon their nature and the way in which they function in the personality. On the other hand, the mental condition of a person deeply influences his religion.

Religion, therefore, far from having no legitimate interest in mental health, cannot afford to neglect it. Indeed, the church has a major responsibility in the area of health, if by health we mean not only the absence or the control of certain kinds of germs, but also the result of the individual's relationship to the world in which he lives, including, of course, other people. Religion, functioning as it does on the cultural as well as on the personal level, also has a responsibility and an opportunity for changing and developing cultural patterns in the interests of the health of the group. Just as religion may foster either healthy or unhealthy beliefs and attitudes in individuals, so it may foster either healthy or unhealthy patterns on the group level.

How, then, may the church discharge its responsibility in the area of education for healthy living? In general, the answer to this is that it should do so through the regular group functions that take place within the church or under the auspices of the church. In other words, the most effective work does not require that any new machinery be set up.

Two kinds of group activities are to be found in every church that have potentialities either for mental health or for mental illness. These may be classified into ceremonial and educational activities, though the distinction is not absolute. Among ceremonial activities would be included worship services, baptisms, weddings, funerals, and other such occasions. Freud has pointed out the relationship between ceremonials in religion and certain neurotic manifestations. This,

however, is only a small part of the total picture. Worship may indeed be utilized to reinforce neurotic traits, or it may be used to change beliefs and attitudes, to influence growth of personality, to promote integration, and thus to produce health. It may also be used to confirm and strengthen outworn and unhealthy cultural patterns or to promote change on the cultural level. It is thus a two-edged sword which may cut in either direction. Its use is largely, though not entirely, controlled by the clergyman in charge. On this subject a great deal of research and study needs to be done, but this calls for a kind of training that the average clergyman to-day is not receiving.

An integral part of the worship services in Protestant churches is the sermon. Here again is a real opportunity for influencing individual and group attitudes and beliefs, and for presenting interpretations of life and religion on which wholesome living may be based. Two kinds of clergyman may err at this point—the clergyman whose own attitudes and beliefs are not wholesome (judged from the point of view of mental health) and the clergyman who has not received adequate training in the field of mental health.

The writer's experience as chaplain in a mental hospital may be of value here. Naturally, sermons preached in such a situation must be both sound religion and sound mental hygiene. This is not so difficult as it may appear on the surface, once an understanding of the problem is achieved. Moreover, the writer has found that sermons prepared for hospital patients strike a very responsive chord in congregations to which he preaches from time to time in the community. From both the religious and the mental-hygiene point of view, there is no problem encountered on the wards of the hospital or in a congregation of patients that is not found also in every parish and church in the community. It may not appear in the community in so exaggerated a form as in the hospital, but it is there. Indeed, religion and mental hygiene are, to a large degree, different approaches to the same human problems, and each has a great deal to contribute to the other. Worship services and preaching offer the clergyman unique opportunities, not only in religion, but also in community education for mental health.

A word about other ceremonials in religion, such as baptism, confirmation into the church, weddings, and funerals. It should be noted that these are all related to very significant experiences in the life of the individual and of the group. Baptism and confirmation are ceremonies through which a new individual is added to the religious group; at the wedding ceremony a new group is formed within the larger group; at a funeral, a member is lost from the group. Both for the individual and for the group, these are important occasions and they frequently constitute emotional crises. They may be conducted in such a way as to promote integration and growth within the individual and within groups, and to strengthen those sound personal relationships which are vitally essential to the health of the individual and of the culture, which are also important for religion, and which are very frequently missing in our mechanized culture. Or they may be conducted in a way that does not conduce to these deeper values or that even tends to destroy them. Here again a great amount of study is needed, and again this waits for the kind of training of clergymen that makes such study possible. The task of the modern clergyman is to develop the techniques of religion in the light of modern knowledge, and he needs a kind of training that will make him equal to this task.

Through the educational activities of the church, as well as through the ceremonial, a real contribution may be made toward community education. There is, for one thing, the church school, which usually contains classes that include all ages. In the selection of the courses for these groups, the clergyman has an opportunity and a responsibility. The content of the material taught needs examination from the point of view of mental health. More important, perhaps, is the selection of teachers. One church within the knowledge of the writer requires that each prospective teacher be interviewed by two persons (one being the clergyman) who attempt to pass on the personality qualifications of the applicant and to eliminate unstable persons. Such a procedure should be much more widespread. Many unstable persons are attracted to various forms of religious activity, such as

teaching, and a well-trained clergyman can render a real service by preventing such folk from obtaining positions of influence, especially over children. He can also render a real service to unstable persons by guiding them into activities that will be helpful to all concerned.

Very pertinent at this point is the leadership and guidance that the well-trained clergyman may give to young people's groups, mothers' clubs organized within the church, and other such groups. As a rule these groups are eager for education along the lines of mental health. This education, however, should possess elements of continuity and progression, and should be integrated with the emotional and other needs of the individuals involved. The clergyman does not need to assume the actual leadership of such groups himself, but he may be of inestimable help in guiding the program and in suggesting capable leadership from the community.

Such educational activities within the church offer several advantages. One is the fact that many persons of all ages can be reached who might not be reached in any other way. Another lies in the fact that membership in church groups is comparatively stable. This means that the program can be carried out over a sufficiently long period for new ideas to become emotionally accepted by the persons involved. Education of this kind requires patience on the part of the leader, and sufficient understanding and tolerance to permit of those inner processes through which an individual digests and assimilates ideas that are new and perhaps contradictory to his philosophy of life. The realization that many people have of their own inadequacies and unhappiness assists in this process. But growth cannot be forced without harm, and the stability of the average church group warrants the allowance of sufficient time for normal growth.

Another advantage, provided the clergyman is adequately trained, is that through his many opportunities for personal contact with his people he may give individual counsel where it is desired and needed, or he may guide those who need further aid to some other professional worker, such as a psychiatrist or a social worker.

A discussion of community education for mental hygiene through the church would not be complete without some men-

tion of the possibilities for coöperation between churches and the mental-health agencies in the community. Such coöperation may take place between a church and a clinic or through organized groups of churches and a clinic or a mental hospital. A review of two projects that have been carried on in Worcester will illustrate the latter type of coöperation.

Some eight years ago a project was developed between the Worcester State Hospital and the Worcester Federation of Church Women's Societies. Through the social-service committee of this federation, which includes about eighty churches, a group of women were selected to visit certain wards on the female service of the hospital. The women were paired and each pair was assigned to one ward. The purpose of this visiting was to give the patients a concrete expression of interest and friendliness. Needless to say, this was much appreciated by many of the patients, some of whom had few or no visits from family or friends. Courses of lectures were given to the visitors to acquaint them with the various phases of hospital life, with hospital problems, and with the principles of mental hygiene. These lectures were very popular, and were appreciated by the visitors. Frequent reports were made by the visitors to their organization, thus keeping the organization in touch with the hospital.

On one occasion during the past year two hundred women from the federation accepted an invitation to visit the hospital for a special program which included visiting the wards and other points of interest and also lectures by several members of the staff. The result of this project is that a large group of women in the community know the hospital intimately, feel at home in it, and can talk about it intelligently to their neighbors and friends. This helps to develop the confidence of the churches and of the community in the hospital, and in this way enables the hospital to render a finer service to the churches, to the community, and to its patients. Through this project the hospital has resources in the community that it would not otherwise have.

Another project that aims at community education and coöperation was organized during the past year through the Worcester Council of Churches. When the Council of Churches was approached with the suggestion that a depart-

ment of religion and health be created within its organization for the purpose of formulating programs of coöperation between the hospital and the churches, a favorable response was immediately received from the clerical and lay leaders of the council. This response was the result of a program of community education which the hospital has carried on over a number of years. The members of this department are physicians, clergymen, and laymen.

It is too early to report on the work of this group, as it is not yet one year old. However, it has already offered a successful ten-week course for clergymen which was given at the hospital. Plans for the future include other courses for clergymen, research in mental hygiene and pastoral relationships, a series of talks on religion and mental hygiene over a local radio station, seminars for clergymen and physicians for the discussion of problems of mutual interest, and other such projects.

Within a short time the work of this group has resulted in a clearer appreciation on the part of the leaders of the church of the responsibility that they have in the field of mental health. The relationship between the hospital and the churches that is being developed through it will inevitably produce values that are highly desirable from the point of view of each. Such coöperative endeavors bring results that either group, working by itself, could not hope to achieve. It should not be forgotten, however, that such programs are based on a degree of mutual understanding that is not possessed by all psychiatrists and clergymen. There is something to be said for the inclusion of courses on religion in the medical course, and we shall point out what additions we feel to be highly desirable in the training of the clergy.

Throughout this paper we have stressed the need of adequately trained clergymen. Theological education being what it is at present, it is obvious that the majority of young clergymen are not equipped to participate intelligently in such a program. But skepticism on the part of mental hygienists as to their fitness to do so is justifiable only until desirable additions are made to the training of clergymen. Mental hygienists who understand the values of such an approach as we have been outlining, and who have a broad view of the

problems involved in health and disease, will see in the present situation an opportunity to render a real service to their own cause by bringing their influence to bear on theological education. The fact that the community need is so great, and the additional fact that the average person in our churches is so eager for enlightenment, cannot easily be ignored.

On the whole, clergymen are keenly aware of their own inadequacies in this field. The ever-recurring plea from clergymen is, "Tell us what to do and how to do it." Even mental hygienists and certainly religionists have erred in the past by answering this plea in such a way as to imply that the clergyman should take over the techniques of the psychiatrist and set up something on the order of a church clinic. Without discounting the value of the clergyman's work with individuals, it should be clear that such work should be done by him as a clergyman, not as a psychiatrist, and certainly not as a pseudo-psychiatrist—a constant danger on the part of poorly trained men. In this article we have attempted to point out other aspects of the clergyman's work that are of as great value as is his work with individuals—indeed, when adequately carried out, of even greater value.

We shall not attempt to answer categorically the question of clergymen as to what they can do and how they can do it, as we do not believe that it can be answered in that way. The problem is deeper. It is that of providing the clergyman with a basic training through which he can acquire the fundamental knowledge for working out his own answer to the question.

The kind of training to which we refer is known to-day as clinical training for theological students, and it should be considered a necessary addition to the present theological curriculum. Such training has been carried on in this country since 1925, on a small, but constantly enlarging scale, by the Council for the Clinical Training of Theological Students. It consists of a period of not less than twelve weeks, preferably longer, of residence in a mental hospital, a general hospital, or a correctional institution. During this period the student has first-hand contact with the patients or inmates; he attends staff conference, participates in specially arranged

lectures and seminars, studies the records of the patients, and in many other ways gets a very intimate understanding of the pathologies of mankind. This training is conducted under the dual supervision of a staff officer of the institution and of a specially trained clergyman who serves in the capacity of a theological supervisor.

For a more detail description of the training program, the reader is referred to other literature.[1] Here we shall point out the relationship and the value of this kind of training to the function of the clergyman in community education. In this discussion we shall be thinking primarily of the training in a mental hospital, though much of what we say will be equally applicable to the training in a general hospital or a penal institution.

A basic value of clinical training for the theological student grows out of the fact that it brings him, for the first time in his career, into an intimate relationship with individuals who are suffering from one or more of the many maladies that afflict mankind. He has this experience in a setting in which every effort is being made by various specialists to discover the nature, the causes, and the treatment of these illnesses. This is quite a different experience from reading about such things in books. Neither is it to be confused or identified with the experience that the student acquires in what is known as "field work" in the theological school. This field work takes place in churches, and through it the student comes into contact with various kinds of person. The aims and the type of supervision received in field work, however, are very different than those of clinical training. It is quite a common thing to discover that field work and the experiences of the young clergyman in his first years of parish work bring him face to face with problems with which his seminary training has not and cannot equip him to deal, and here he feels the need of further training of a clinical nature.

Through clinical training under thorough supervision, the theological student receives an understanding of the human personality, its formation, its development, its pathology, and the best modern methods of treatment for its disorders. By this we do not mean that he is taught to treat sick persons;

[1] See *An Opportunity in Theological Education; A Description of Policy and Program.* New York: Council for the Training of Theological Students, 1935.

rather, he is taught the nature of the treatment required in various maladies and the kinds of specialist who are qualified for such work. In this training the sick person is the center of attention, and the student learns the importance of thinking in terms of the person who has the illness, not in terms of an abstract illness. Moreover, the relationship of cultural factors to the person's predicament are duly stressed, and thus the student is taught to approach his work on a broad foundation.

This understanding of persons and of personality-culture relationships is quite essential to the kind of community education of which we have been thinking, in that it offers a necessary foundation for such education. It also helps the young clergyman to avoid one of his most common pitfalls—namely, the tendency to the oversimplification or the overintellectualization of human problems. Constructive changes in the attitude of the young clergyman toward his work also occur as a result of this understanding. As one student wrote upon returning to his parish after a period of hospital training, "I find myself no longer thinking in terms of attacking my problems, but rather in terms of discovering the best approach to them."

Another value of clinical training is that it brings to the clergyman an understanding of the interests, methods, and goals of other workers who are specialists in various phases of the human problem. Constant rubbing of elbows with physicians, psychiatrists, social workers, psychologists, and other specialists on the wards of an institution, along with well-planned discussions with such specialists, brings to the young clergyman a basis for distinguishing between the contribution of these workers and his own contribution, and also offers a basis for his coöperation with them in projects of community education. This kind of understanding between the clergyman and the psychiatrist is essential to community education. The clergyman is in a position seriously to hamper sound mental-health education, either by opposing it or through well-intentioned, but unsound and misdirected activities. The clinically trained clergyman, on the other hand, is in a position to offer a much needed and a sound kind of coöperation.

In regard to coöperation, another fact that should be kept

in mind is the influence that the clergyman and the church may have with other community workers, such as schoolteachers, welfare workers, and those who are responsible for making and executing the laws of the community. The clergyman may occupy a strategic position in relation to such workers and through that relationship may exert a strong influence in the direction either of health or of disease. Several conversations that the writer has had with lawyers in regard to persons who had sought legal advice in connection with marital difficulties have led him to suspect that intelligent coöperation between lawyers, clergymen, and psychiatrists would result in real benefit both to the persons concerned and to the community.

Clinical training, as we have said, gives the young clergyman an understanding of the methods and goals of other specialists. It also gives him a background for understanding the theories of these specialists. The continual exchange of ideas in an intensive training program, the daily demonstration of the values and the limitations of present-day theories in actual clinical situations, results in a kind of insight that cuts underneath either a highly emotional rejection of or an overenthusiasm for modern theories. It helps the clergyman to attain a degree of objectivity that is not possible in an academic situation, and to distinguish the factual from the theoretical. This has many highly important ramifications, one of which we shall discuss.

Among the chief tools of the clergyman are books. He uses them constantly as a source of ideas and also in his educational work with groups. He is frequently asked by his parishioners to suggest books. In a recent discussion in this city as to whether a certain novel should be banned from the public library because of its vulgar language, one of the chief arguments against the ban was the fact that the book had been mentioned favorably by a clergyman from the pulpit. The clergyman is frequently asked about books dealing with problems that have to do with mental health. The clergy as a group offer a large market for the sale of books of a psychological and a psychiatric nature. Yet few clergymen are equipped by training to evaluate these books. Regardless of its intrinsic value, a book written by a psychologist or a

psychiatrist is likely to become a best seller, provided it says something favorable to religion. And the advertiser who writes the blurb for the jacket of the book is likely to exert much more influence than his position deserves.

Through the close association with many specialists that occurs in clinical training, the young clergyman's critical faculties are developed, and he receives a foundation in theoretical and factual material that makes it possible for him to evaluate fairly the books that come into his hands, and to choose skillfully those that he recommends to others. This is a vital consideration in community education for mental hygiene.

Clinical training not only provides a thorough understanding of other specialists; it also gives the young clergyman a deeper understanding of his own unique contribution to human welfare on both the individual and the social level. This includes insight into his limitations as well as his abilities. One of the most important results of clinical training is that the clergyman learns what not to do. He learns these things through his daily contact with sufferers and because the training course, as carried on by the council, constantly focuses his attention on this central problem. The question, What does the clergyman have to offer? is faced every day in a situation that demands practical, realistic thinking. From the wealth of material that is available in the clinical situation there comes a new understanding of the work of the clergyman in the parish. The implications of his experience for parish work are constantly stressed. The young clergyman frequently discovers that after a patient has reached the hospital, there is little or nothing that he can do, but that somewhere prior to commitment, perhaps ten years before, a clergyman might have rendered a preventive service.

Clinical training thus illuminates the task of the clergyman, his preaching, his function in ceremonial occasions, his pastoral relationships, his educational work—in short, his entire task of church leadership. It is essential if he is to assume his proper rôle in community education.

We have outlined briefly the ways in which the clergyman, functioning through his usual offices and relationships, may render real service in community education for mental health.

If our understanding is correct, the clergyman cannot fulfill his functions without having some influence on the health of the community. Because of the inherent relationship between religion and health, the clergyman is an important factor in the hygiene of the community. In order to discharge his responsibilities adequately, he requires a type of training that is available to-day for only a small percentage of those students who are preparing for the ministry. The extension and development of clinical training should be a vital concern both of the church and of the psychiatrist.

CASE STUDIES IN THE SCHOOLS *

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THE present paper is in the nature of a plea for the adoption of a new emphasis in our schools—namely, a definite concern for the promotion of the emotional and personality adjustment of the individual pupil through application of the modern case-study technique. What is behind the child behind the book? How happy is he? How does he feel about life? What conflicts are bewildering or embittering him? What thwartings is he undergoing in the achievement of his extra-school goals and purposes, and of his in-school goals and purposes? If he is ill-behaved, why is he ill-behaved? How can he be helped to improved conduct? If he is timid, or introverted, or negative, or afraid of life, how can the factors that are eventuating in these unfortunate attitudes be controlled? If he is a braggart, or a bully, or an unhealthy seeker after the limelight, or a pseudo-delinquent, what forces are impelling him and how may they be counteracted? If he is lazy, or a daydreamer, or a hopeless procrastinator, what unsatisfied desires are activating him and how can he be dispossessed of them, or how can they be redirected into more desirable channels? If his total influence in the school setting is disruptive, if he is an actual or a potential center of disaffection in the ranks of his mates, what motives are back of his conduct and how can he be helped to adjust positively and aggressively to the schoolroom situation and to the community or the home situation?

Questions such as these are baffling a great many classroom teachers to-day. In an artificial and mechanical age, we have been so far dragged away from personality values and so deeply immersed in physical and economic and material preoccupations and projects that our homes, our communi-

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ties, and our schools and social organizations generally are in danger of becoming vehicles for instilling, cultivating, and perpetuating a mechanistic brand of culture that leaves boys and girls, and adolescent youth, scant opportunity for developing those securities and loyalties, those substantial emotional satisfactions, those safeguards and controls of the personality, without which true human adjustments and satisfactions are unachievable.

Our child-guidance clinics are besieged by great numbers of parents and teachers who desire aid for a vast army of individual children whose problematic conduct and behavior present a sad commentary upon our brand of civilization in general and, in particular, upon the adequacy of our schools to further emotional and personality adjustment in the legions of children who pass within their portals. Every consultant psychologist and every practicing psychiatrist, as well as most thoughtful laymen, recognize this unfortunate condition, and most of us are convinced of the urgent need for some solution. In a nation in which upwards of 200,000 children are haled into juvenile courts every twelvemonth, and another 200,000 are delinquent, but are not taken to juvenile courts because such facilities are not available in the community—in which, too, the disturbing realization is growing that crime and delinquency have penetrated downward not only to the adolescent, but to the pubescent and even to the pre-pubescent group—it is high time that we paused to review a fundamental shortcoming in our educational system.

The educative process in this country has consisted rather exclusively of conducting boys and girls through a somewhat academic course of study in the original three R's—and a dozen or so latter-day R's!—and, since the last war, of providing something in the way of health supervision and formal physical education. Throughout the history of our public-school system in America—as well as in most other Western nations—we have from time to time added to the established curricula as developments in the world outside the school have seemed to warrant. When, in the early 90's, for example, science reached industry and so precipitated a new industrial revolution, it was deemed imperative to introduce

into the secondary school the study of science. Again when, as in the '20's, it appeared that there was danger of our people's forgetting that the Constitution is the Supreme Law of the land, study of the Constitution was added to the already overcrowded curriculum. In various parts of the country, various other addenda to the school program have been made *pari passu* with events and developments in the world outside—*e.g.,* courses in radio construction, courses in soil analysis, courses even in cross-word-puzzle construction!

Whenever new mechanical or material acquisitions have been made by the race, society has been meticulous in seeing to it that the rudiments of the technologies underlying them are supplied by the schools. We have in consequence been so occupied in building, revising, and rebuilding curricula calculated to fit our mechanical situation that we have overlooked the deeper and more profound problems of individual adjustment which the machine itself has in considerable measure created. We have made the course of study sacrosanct and inviolable, and have insisted that it be followed through in lock-step fashion. We have been intrigued with problems of content, of minimum essentials, of correlation, of objective measurement of results, of mechanical testing and classifying, of teaching methodolgy and economy, and the like. We have been worshipers of the norm; we have neglected individual deviates in our zeal to guarantee or to achieve medians; we have set in order mass projects, mass programs, mass standards and techniques; we have bowed ourselves down to the heathen divinity of the norm; we have, in brief, reduced the learner to the same mechanistic plane as the materials we teach him.

True, we have realized through it all that something was amiss in this mass, mechanical, lock-step system of public education, and we have from time to time sought to ameliorate the situation somewhat by the inauguration of Dalton plans, of Winnetka plans, of Morrison plans, of parallel-track plans, of schemes for individual promotion and for enrichment, of special-class education, of "opportunity" schools, of exploratory and pre-vocational courses, of school research departments and bureaus, of special teachers and supervisors, of differentiated programs based to some slight degree

upon individual bents or preferences, and a score more pedagogic innovations calculated to lull us into believing that we were by such devices and efforts adequately serving the pupil himself as an individual and as a personality. To the challenge of a complex age, the baffled school has reacted hopefully by making its offerings more complex and varied.

The fundamental problem of childhood and youth in a machine age has not, however, yet been satisfactorily attacked save in isolated and sporadic instances. The impact of our present-day industrial civilization upon all of us has been profoundly disconcerting and confusing. Nobody among us knows whither we are bound nor by what star to set our course. Nobody knows absolutely that our civilization is not doomed and the dusk of the gods already at hand. It takes high courage and stalwart faith to-day for any of us to push forward hopefully. The present parent generation is restless, insecure, apprehensive; it is tremendously keyed up nervously and emotionally. We are anxious, irritable, panicky; we slash around energetically, but make little headway; in our homes we are preoccupied, unstable, uneasy, and beset with a thousand cares and worries; even in our relaxations we are too often dissipated rather than re-created. Man's civilization may yet turn out to be the Frankenstein monster that will destroy him.

It could hardly be expected that childhood has escaped or can escape the unfortunate concomitants of a mechanical civilization. If the parent generation is affected adversely by the forces of modern society, how much more unfavorable is their impact upon the childhood generation. Where there are strain and uncertainty in any of the primary social institutions—and notably in the home—there is bound to be repercussion upon the young. Unrest or instability in the home exerts a far more disturbing influence upon the adjustment of the children than it does upon that of the adults.

Largely because of these conditions, teachers and administrators are to-day faced with a school generation that includes within its numbers far more maladjusted individuals than could possibly have been the case in any previous age. There is no time in this brief paper to go into the problem of inadequate home backgrounds as they have been and are being

created by our mechanical and jazzed-up civilization. It is enough here to call attention to their juvenile product as it exists in your school and mine.

Mixed in somewhat conspicuously among the stable and well-adjusted pupils in any schoolroom are to be found those individuals who have lost their security, those who are worried and unhappy, those whose personalities are a battle-ground of conflict, those who are rebellious or actually defiant, those who are failing, those who are irresponsible, those who are negative or inferior or lazy, those who have been thwarted and belittled, those who have failed to build up loyalties, those who are cynical, those who are indifferent, those who are misunderstood, those who have remained emotionally infantile and unweaned or spoiled or over-repressed, those who are daydreamers, those who have grown up with little parental guidance and understanding, and whose habits and attitudes and conditionings are in consequence glaringly inadequate for successful and positive school adjustment.

If we add to these unfortunate products of inadequate homes the great company of children who are but moderately endowed, and who have been accustomed to experience failure rather than success, or who have been compelled to do schoolroom tasks for which they have had little aptitude and in which they have felt no interest, or who have been pushed faster than they could go or held back to a slower pace than they might have gone, or whose inclinations or endowments have been overlooked, or who have been mistaught by bungling teachers—if we add up all these groups, we shall arrive at some reasonably adequate idea of the sins of omission and of commission which our society, our homes, and our educational system have perpetrated upon defenseless childhood and youth.

Speaking both as a psychologist and as a consultant in guidance problems, I have no hesitation in affirming that the revamping of the educative forces of the community—and notably, of course, the school—to meet these pressing problems of personality and adjustment represents perhaps the one most urgently needed undertaking of our schools to-day. Drilling upon formal (or informal!) educational materials is patently failing to equip properly considerable

numbers of young persons for life in the complex modern scene, necessary though such emphasis must continue to be. The new education may introduce programs of vocational counseling and guidance, may adopt a strongly utilitarian purpose, may provide for self-expression through increased freedom and through activity units, may surround the learner with all the philosophy and the paraphernalia of the so-called "progressive" schools—all these things will fail to redeem either the school or the product of the school. The new education will fail throughout large areas of its efforts until it is ready to return to the individual and his adjustment life. It must concern itself with feelings and emotions, with the personality, with the reduction of inner conflict and turmoil, with the building of positive and dynamic character, with the uprooting of inferiorities and fears and resentments, with the cultivation of happy and wholesome mental attitudes, with the elimination of antisocial traits and the fostering of socially desirable ones.

To achieve this purpose in education, every child will have to be treated as an individual to understand and analyze whom is just as essentially a function of the school set-up as is the more limited teaching function. To the Occidental, all Chinamen look alike. Too long all children have looked alike to the school and its personnel. It must now accept the essential task of diagnosis and readjustment, at least so far as the unadjusted pupils are concerned. Every child who is not adjusting well in school must be considered a case for intensive study. Nor will it be sufficient merely to establish his I.Q. and his A.Q.[1] Innumerable children who are well enough endowed intellectually are disappointments or actual liabilities in the school situation because of emotional or personality defects for which the conventional school set-up has neither diagnostic nor corrective machinery. Children whom we have been content to label variously as "obstinate," or "lazy," or "rude," or "erratic," or "nonconforming," or "mischievous," or "sulky," or "dishonest," or "shy," and so on, turn out, in the light of the principles of mental hygiene, not to be innately vicious or depraved, but

[1] Achievement quotient—*i.e.*, the ratio between a pupil's standing in his school studies and his chronological or calendar age. Theoretically at least, a ten-year-old child ought to be doing the work of average ten-year-olds.

rather to be employing these and numerous other abnormal behavior patterns merely as escape or defense mechanisms through which they may protect their personalities or otherwise achieve some substitute emotional satisfaction.

It is no longer to be considered good educational practice to send a nonconforming child to the principal; or to quarantine him socially from his fellows by requiring him to sit for an hour or two a day on a bench outside the schoolroom door in humble penance for his sins; or to read to him publicly or privately long lectures on moral turpitude, lack of social coöperation, or the evils of his unregenerate ways; or to send sharply critical notes home to his parents requesting them by some miraculous or subtle necromancy to make him over. These time-worn devices for dealing with the unadjusted child, and a dozen more of the same ilk, are as outmoded in the educational world as is the much-talked-of dodo in the biological. They are for the most part worthless because they propose merely the treatment of external symptoms, leaving the fundamental condition that produces the symptoms *in statu quo ante*. As well expect the physician to rid his patient of fever by administering a drug without bothering to inquire into the nature of the organic malfunctioning that produces the fever! Only through the thoughtful and intelligent application of the case-study technique can either the teacher or the physician hope to arrive at the logical and dynamic causes of the maladjustments of their respective charges.

But how shall we introduce the case-study technique into our schools? We have not the skilled social workers and clinicians and psychiatrists who are assumed to be essential for the carrying out of careful case studies. Our teachers are trained to be *teachers,* not *social workers.* The crowded curriculum and the heavy teaching load preclude their devoting any great amount of attention to extraneous matters such as the diagnosing of behavior problems. The day is hardly long enough as it is to accomplish the aims of the course of study. Besides, there is danger of doing irreparable damage to the personality when a novice undertakes to delve into its adjustment disorders. While these things are all undeniably true, the fact remains that unless the

school does take the initiative in attempting to straighten out some, at least, of those disorders, there is no agency that can be expected to undertake it. In relatively few of our towns are such facilities as psychiatric and guidance clinics available, and the clinics that do exist cannot remotely begin to meet the demands that are made upon their resources. The school remains necessarily the only agency in most communities that is in a position to initiate and carry forward diagnostic and remedial programs for emotionally maladjusted children and for those who present behavior problems in their schools.

For the sake of objectivity in this discussion, let us assume a typical school set-up in a typical neighborhood. Included among the pupils, let us say, are ten children who are adjusting in so unsatisfactory a way to the general school situation as to merit individual case study. For the purpose of this paper, let us confine ourselves further to one pupil in the sixth grade—Peter.

Peter, though of normal intelligence, is failing in arithmetic this year, and he was passed in this subject last year only because the teacher wanted to be rid of him. Peter's grades in the content subjects are becoming progressively poorer. Furthermore, he is beginning to show various forms of undesirable conduct, such as pushing, throwing down, and tormenting smaller children, engaging in obscene talk on the playground, playing truant, and stealing small articles from other children. Peter is coming to be recognized as far more of a liability than an asset in the school environment.

Now what will happen in nine out of ten schoolrooms—might I safely say, ninety-nine out of a hundred?—is that Peter will be frowned upon and scolded by the teacher, sent periodically to the principal, complained of in futile notes to the parent, sent home, commonly referred to among all the teachers as an impossible or vicious child, held up to the scorn—though actually it may be to the admiration—of the other pupils, and perhaps even dismissed from the school. Meantime, the boy's conduct does not improve—who could expect it to?—and the problem of maladjustment goes unsolved, one might almost say *unattacked.*

Instead of all these useless or actually vicious techniques,

let us see how a thoughtful individual case study of this boy will help. His home-room teacher, as should ordinarily be the case, is charged with the responsibility of supervising or heading up the study. Her first task is to assemble all the data that the school has already collected at various times about Peter since he entered the first grade. On a specially prepared case-record sheet, which the superintendent has made available for all such investigations, the teacher will assemble the data on the results of the cumulative medical and health inspections and on all corrective work that has been done for any physical defects that Peter may have or have had, together with his intelligence rating and his mental age. She will also graph in their proper place all scholastic grades that Peter has received in the preceding school years, in order to discover trends, points of weakness and strength, and so on.

These more or less mechanical details having been brought together on a case-record sheet, and Peter having thus been lifted out of the mass of children for intensive study, she proceeds to interview those teachers in the grades below hers who have had Peter in their rooms. In these interviews she secures and records information regarding the boy's adjustment and general behavior, grade by grade, as he has come up through the school, possibly using an approved check list of traits for entering the opinions and convictions of the several teachers.

She is now ready to request that the principal summon a case conference to consider the specific problem of Peter. Those who participate in the initial case conference include herself, the other teachers who know Peter, the school nurse if there is one, the principal, and, it is to be hoped, the superintendent. At the conference the home-room teacher acts as chairman, stating first of all the specific adjustment problem of Peter and then summarizing the information that she has obtained from the various individuals indicated above.

After the facts have been placed before the case conference, a general interpretation is called for, the problem is restated in the light of the combined insight of the participants, and a suggested line of corrective procedures is determined upon. In the course of the discussion, it may well be

that the question of Peter's home background will be brought up. It may be that there will emerge a need for somebody to visit the home and endeavor to interpret the school and its tasks more intelligibly to the parents; it may be that the need for special home coöperation in carrying out the correctives proposed will be recognized; it may be that the social, or emotional, or physical adequacy of Peter's home is questioned. Whatever the situation, the conference may agree that a sympathetic and friendly contact needs to be made with the child's home.

Again, if such is the case, it is the present teacher of the child upon whom the responsibility should properly devolve, except in special circumstances which it is not necessary to discuss here. It is to be hoped that the visit she makes to the parent will not be the first one ever made by any of Peter's teachers; unfortunately in not a few cases it probably will be. During the visit, which may turn out to be but the first of several valuable contacts with the parent, the teacher will have an opportunity to gain a fairly good idea of the relationship that the boy's home situation may have to his failure in school adjustment. She will, after a little experience as an interviewer, develop not only tact in securing the information she wishes, but some degree of insight into the actual home setting as it may relate to the school difficulties of the boy; and this skill will stand her in increasing good stead in subsequent visits with other parents.

It may be that the nature of the child's problem will be such that an interview with Peter's Sunday-school teacher, or with some social or welfare worker who knows the family, or with a scoutmaster, or with some other responsible person, may be indicated. In such circumstances, responsibility may well be assumed by the principal, or the superintendent, or the school nurse, or some other member of the school organization.

In the second case conference, all these lines of evidence and investigation are brought together and the conclusions are carefully interwoven with the original data. The conference is now in a position to revise or to extend its previous recommendations and to restate the entire case in a

more exact manner. An entry is made upon the record sheet summarizing the situation and outlining the further corrective procedures to be followed. The conference then adjourns, subject to later call as needed.

In the following weeks the entire school organization, under the direction of the teacher, endeavors to carry out the plans that have been determined upon for the readjustment of Peter. By no means least among the contributions that most of the individuals concerned can make will be the manifestation of an optimism and an encouragement regarding the successful outcome of the case that will be in sharp contrast with the all-too-prevalent tendency among school people to look somewhat cynically upon the child who presents a problem and to anticipate the worst in him.

The teacher herself is throughout the entire period of corrective treatment the individual who applies or directs the technique agreed upon. It may involve further consultation with the parent; it may involve special coaching in some one or more of the school subjects; it may involve seriously sympathetic and private conferences with Peter himself; it may involve advising with the school nurse, or with the attendance officer, or perhaps a private talk with Peter's closest chum; it may involve a recasting of the teacher's own methodology, or even a yeoman attempt to correct some of her own personality or emotional traits that are affecting Peter's adjustment; it may involve the interesting of a neighbor, or of an employer, or of a social agency in Peter's problem.

Whatever the implications and whatever the correctives, there should be periodic summaries of progress and a final case conference in which the case may be marked as "closed" and the adjustment of the child as now "satisfactory" or "greatly improved." Occasionally, of course—since after all human nature is an uncertain variable and since our human techniques are at best bungling and inadequate—there will be cases that will have to be marked "failure," or "doubtful," or "unimproved." Such unsuccessful outcomes of treatment are experienced by all practitioners in human relationships, and are to be expected. The mere fact that such efforts as we are proposing in this paper do not result

satisfactorily in 100 per cent of the cases should not be construed as evidence of the futility of these efforts. A single child saved from maladjustment is worth all the efforts and all the thought that we can bring to bear.

In the case of the boy, Peter—who is a real boy, by the way, and not a figment of an armchair psychologist's brain—the case-study and case-conference technique was almost thrillingly successful. It developed that Peter had been out of school ill for about two months in the third grade, during which time he missed some important drill in the fundamental processes of arithmetic which he did not subsequently get. The result was a long series of difficulties in arithmetic in the two following grades, culminating in actual failure in the fifth.

When Peter's first poor grades in arithmetic began to reach his home, the boy was assured by his mother that his father had always been poor in arithmetic, and that Peter came naturally enough by his own weakness in it. Peter idolized his father, and in that fashion well known to psychologists, he now began to identify himself with his father to the point even of being willing, possibly actually delighted, to be poor in arithmetic "just like dad." Conflict arose, of course, in Peter's mind between what the school expected of him and what he would have been content to be. His teachers scolded and embarrassed him; the boys jibed at him; his mother upbraided him more or less. The upshot of it all was that the division of Peter's loyalties between his father and his school, together with the cumulative effect of his poor training in arithmetic in the third grade upon his subsequent performance in arithmetic, drove him to develop behavior difficulties, as so often happens when one originally somewhat circumscribed area of maladjustment spreads to other related areas.

Correction and readjustment in Peter's case were not difficult to accomplish. The teacher, once she had learned that the boy had missed essential drill in the fundamentals of arithmetic, provided him with some extraordinarily well-motivated drill, and Peter shortly made the flattering discovery that he could perform as well on standardized objective arithmetic tests as any boy in his class. By a little

human artistry such as all teachers need, but too few possess, this teacher protected Peter's loyalty to his father by helping him to appreciate the cleverness of his father—who, by the way, was a carpenter and builder by trade—in making exact measurements and in erecting buildings that stood foursquare to the world.

Peter's next report card—which was accompanied by a note to his mother calling her attention to the fact that the boy had missed certain important drill, which he was now having, and that the results were beginning to show in his arithmetic grade—made his mother proud of him. The principal took occasion, when a casual opportunity arose, to assure the mother that Peter was coming along; the superintendent happened to meet Peter's father one afternoon, and referred to the fine progress he understood Peter to be making in his new grade. With his conflict thus relieved, of course Peter's conduct improved phenomenally. Had the proper technique not been applied, it is easy to see how this sixth-grader might have been just one more unadjusted child going to swell the ranks of the inadequate, the rebellious, and sooner or later perhaps even the delinquent.

The case of Peter was a relatively simple one, and one that yielded promptly to study and treatment. Some behavior problems in children are obviously too complicated and require too specialized a technique for the rank and file of teachers to handle. But the vast majority of cases of maladjustment, educational, emotional, or social, are little, if any, more involved than the case of Peter, and there seems to be no satisfactory reason why the case-study and case-conference technique which we have been presenting in this paper cannot be applied with gratifying results by the teacher, the principal, and the superintendent, acting as an adjustment unit.

In concluding this paper, I should like to call attention briefly to four important considerations for the introduction into our schools of the case-study technique:

1. The classroom teacher must be brought to an appreciation of the fact that, except in unusual cases, all children of reasonably normal intelligence who develop school or subject-matter aversions, behavior difficulties, or personality

defects are harboring unhygienic emotional attitudes which can be corrected, or at least greatly ameliorated, by the sympathetic efforts of the school people themselves, notably the *teachers*.

2. The function of the classroom teacher in a complex age can no longer be restricted to the performance of the conventional instructional and supervisory duties. Increasingly, her province will have to be broadened to include a considerable area of social work, since, after all, teaching is and should be considered social work in the best sense of the term. Even after visiting teachers have become more numerous in the community than they now are, there will still remain a vast deal of contact work and actual consultative work which only the classroom teacher can be expected to undertake in the interest of promoting the better adjustment of individual pupils to the activities, the ideals, and the general atmosphere of the school.

3. In order to provide for the more serious and complicated problems of child maladjustment that demand the application of skilled therapy, the superintendent should familiarize himself with the available clinical resources of his section of the state in order to be in position to take advantage of whatever expert assistance they have to offer for the study and reëducation of children of this type. While the number of children who stand in need of special psychiatric attention may be small in most communities, it is essential that if any facilities are available from a neighboring larger community, from a mental hospital, from a guidance clinic, or from any of the state bureaus or departments, they be known and listed for future use as necessity may arise.

4. In any school system, large or small, the superintendent should work out with his teachers a reading and discussion course in the general principles of mental hygiene as applied to the schoolroom and to the handling of children and young people. There are several standard books already on the market, any one of which should provide ample material for a full semester's study by the faculty. Group discussions and general check-ups should be followed through systematically, under the superintendent's guidance. The study of mental hy-

giene and of adjustment problems has made its appearance in teacher-training institutions only recently; consequently the rank and file of in-service teachers have had no introduction to this highly important field. Extensional courses in mental hygiene for teachers should be arranged where practicable; summer-school courses should be demanded by superintendents and made available for those teachers who are required or who elect to attend summer schools; institute and convention speakers should be sought who are able to present adequately the importance of mental hygiene; state traveling or demonstration clinics should be invited to make their services available widely throughout every school community. In these ways and by these means it will be possible to orient teachers and schoolmen generally to a proper understanding of the potentialities of case-work in the ordinary school environment.

THE INTERPRETATION OF PSYCHOLOGICAL TESTS IN CLINICAL WORK WITH CHILDREN *

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THE extensive use of intelligence tests has been a rapid development within a comparatively short period of time. Binet's tests were not described in the psychological literature until 1905, and were not organized into the form of a scale until 1908, although Binet and Simon had been working upon the project for some years before that. Goddard observed the Binet tests in actual use when he went to Europe in 1908. In December of that year he introduced them into this country by publishing a translation and a brief description of them. In 1911 Binet's revised version of his scale appeared, and in 1916 a translation of this work was published.[1] Meanwhile, Terman revised and enlarged the 1911 Binet scale, standardized this revision on the basis of the results from testing 905 American children under fourteen years of age and a smaller group of adolescents and adults, and published an account of this work in 1916.[2] Kuhlmann made another revision and extension of the original Binet, which was published in 1922.[3] The Kuhlmann-Binet was the first scale to provide a series of tests for infants;[4] it included tests for three, six, twelve, and eighteen months and for two years, while Terman's earlier revision began with the three-year

* Read, in part, at a meeting of the Philadelphia Pediatric Society, May 9, 1939.

[1] See Goddard's introduction to *The Development of Intelligence in Children*, by A. Binet and T. Simon. Baltimore: Williams and Wilkins Company, 1916. pp. 5–7.

[2] *The Measurement of Intelligence*, by L. M. Terman. Boston: Houghton Mifflin Company, 1916.

[3] *A Handbook of Mental Tests*, by F. Kuhlmann. Baltimore: Warwick and York, 1922.

[4] Gesell's *Mental Growth of the Pre-school Child* (New York: The Macmillan Company) was published in 1925, and Stutsman's *Performance Tests for Children of Pre-school Age* (Worcester, Mass.: Clark University Press) in 1926.

level. But for school-age children, Terman's revision, known as the Stanford-Binet, was probably the most widely used in clinical practice from the time of its appearance in 1916 until 1937, when Terman and Merrill published a new revision of the Stanford-Binet, which was better standardized than the old Stanford-Binet and also had a wider age range of tests.

The new Stanford-Binet starts at the two-year level and provides tests at half-year intervals for the ages from two to five years; the old scale had tests only at yearly intervals for the ages three to five. Furthermore, the new revision provides tests for eleven, twelve, thirteen, and fourteen years, while the old scale offered no eleven- or thirteen-year tests, having two-year intervals between the ages ten to fourteen. The new Stanford-Binet also has a larger number of tests at what are called the average and superior adult levels (above fourteen years) than the old one.

A corrected table for the calculation of intelligence quotients (I.Q.'s) for children over thirteen years of age is furnished for use with this new Stanford-Binet scale. The old method of calculating the I.Q.—by dividing the mental age obtained on the test by the exact chronological age up to sixteen years and thereafter using sixteen years as divisor—had been called into question, some psychologists claiming that fourteen or fifteen years, rather than sixteen, should be the point at which the exact age should no longer be used as divisor. As a result of these differences of opinion as to the best method of calculating the I.Q., some variations of method arose in clinical practice with the old Stanford-Binet, when I.Q.'s were computed for children over fourteen years of age. The corrected I.Q. table for the new revised Stanford-Binet presumably meets this situation by providing a more acceptable method for calculating the I.Q. for older children.[1]

As might be expected with so many changes in the scale and with some change in the method of calculating I.Q.'s, the results of testing with the revised Stanford-Binet tend to differ somewhat from those obtained with the old Stanford-Binet. Hildreth, for instance, comparing the results obtained

[1] For a more detailed description of the new revised Stanford-Binet, with directions for giving and scoring the tests, I.Q. tables, and so forth, see *Measuring Intelligence*, by L. M. Terman and M. A. Merrill. Boston: Houghton Mifflin Company, 1937.

with the old and the new scale in a group of Lincoln School children whose central tendency was toward an I.Q. of 120, states that a greater increase in I.Q. was found when children were retested by the new Stanford-Binet than when they were retested by the old Stanford-Binet. Hildreth also notes that with the new revision there was a tendency toward a larger increment in score between the age levels of ten and sixteen than with the old revision.[1] However, there are correlations from .64 to .80 between retests with the old and the new Stanford-Binets, according to Merrill's report on test-retest data with the two scales in a group of 1,517 elementary-school children.[2]

Not long after Terman's original revision of the Binet scale was made available for individual testing, the group tests began to appear. During 1917 and 1918, the army Alpha and Beta group tests were devised by psychologists working with army personnel problems.[3] It was not long before other group tests were devised for use in educational guidance work with children. These group tests for children now include intelligence tests, tests for educational achievement, tests for the diagnosis of reading disabilities, tests for the measurement of aptitude for mechanical work, tests for the measurement of artistic talent, and so on.

The group tests have the obvious advantage that a large number of children can be tested in less time than if the tests were given separately to each child, but there is the disadvantage that personal observations, which are a valuable contribution when testing is done individually, cannot be secured when tests are given to children in a group. Therefore even those tests that were devised for group testing are more satisfactory when applied in an individual testing situation, where the responses of the child may be observed and the test results interpreted in the light of the observations. The following illustration from clinical case material indi-

[1] See "Retests with the New Stanford-Binet Scale," by Gertrude Hildreth. *Journal of Consulting Psychology*, Vol. 3, pp. 49–53, March-April, 1939.

[2] See "The Significance of I.Q.'s on the Revised Stanford-Binet Scale," by M. A. Merrill. *Journal of Educational Psychology*, Vol. 29, pp. 641–51, December, 1938.

[3] See *Psychological Examining in the United States Army*, edited by Robert M. Yerkes. (Memoirs of the National Academy of Sciences, Vol. 15.) Washington: Government Printing Office, 1921.

cates how individual observations may provide information that cannot be obtained in the group testing situation.

A twelve-year-old girl was having trouble with school work, especially with arithmetic. She had done very poorly on the group achievement tests in arithmetic at school and was failing her daily work in that subject. There was a question as to whether she might be mentally deficient and should be transferred to a special class, or whether she was normally intelligent, but had a special disability in arithmetic and needed tutoring in that subject.

When she was given form L of the revised Stanford-Binet, she made an I.Q. of 92, which indicated that she was but little below the average intellectually. The achievement test in arithmetic that was used at the clinic was similar to the achievement test that she had previously had with the rest of the pupils in her school class. Her score on this test was very poor and she did most of the examples incorrectly, just as on the test given at school. But at the clinic, where she was taking this test alone instead of with a group of children, it was possible to observe her method of working on arithmetic problems. It then became evident that her method of doing arithmetic could never, except by chance, enable her to obtain any correct solutions, for she invariably began to add, subtract, or multiply starting with the left-hand column of figures and working from left to right, instead of starting with the right-hand column and working toward the left.

Thus the tests could be interpreted on the basis both of the numerical scores and of these observations. We could say that this girl needed special teaching in arithmetic rather than placement in a special class for mentally deficient children and, since our observations revealed the chief source of her difficulty with arithmetic, we could pass on this information to the teacher who was to tutor her. The girl's erroneous method of working on arithmetic could not be observed in the group-testing situation, nor would it have been easy for a teacher to detect it in her daily work. In looking over the girl's tests or her daily papers in arithmetic, all that would appear would be that her solutions to problems were almost always incorrect, but the method of work that made them so would not be evident.

It is necessary to interpret psychological tests not only on

the basis of the numerical scores, but also in the light of our understanding of the child from information that may have been supplied by parents and others and from his own reactions and conversation during the testing interview. In group testing, this personal material cannot well be secured, for in that situation there is no opportunity to observe the responses of an individual child or to enter into personal conversation.

The group tests have a real usefulness in a school testing program because they are a time-saving device. The ideal program for the psychological testing of school children, however, would provide adequate facilities for supplementing the group tests with individual testing and case studies of pupils who rate low on the group tests or who are having serious trouble with some particular school subject.

In the early days of psychological testing, it was believed that the I.Q. obtained from a single test furnished not only a diagnostic picture, but also a prognosis of the child's capacity for mental development. Studies of groups of children who were tested and retested did not confirm the assumption that the I.Q. obtained from the first tests would almost invariably remain constant and stable through the later years of the child's life. Florence Goodenough has summarized data on the constancy of the I.Q. from a number of the studies published prior to 1933.[1] Most of the studies of school children who were retested after a lapse of time indicate that in about half of the cases the I.Q. on successive tests will not vary by more than five points; but in the remaining half of the cases the variation will be greater than five points, and in approximately 4 per cent there will be a change of 20 or more points in I.Q. on a second test as compared to the first test. The change in I.Q. may be in either direction, higher or lower. The figures just quoted are for data obtained when the old Stanford-Binet was used both for the first tests and for retesting. In studies reporting similar data when group tests were used, the constancy of the I.Q. was even less and a greater variation appeared between I.Q.s on first and second testings.

Research data indicate that the I.Q. tends to be less constant if the children were first tested under the age of six years than if they were over six years old when first tested. In one

[1] See "The Measurement of Mental Growth," by Florence Goodenough, in *A Handbook of Child Psychology*. (Second edition, revised.) Worcester, Mass.: Clark University Press, 1933. pp. 303–28.

group of more than 400 children, only 4.3 per cent of those first tested when more than six years of age varied by more than 20 points in I.Q. on the second test as compared with the first test, while of those first tested under six years of age, 19 per cent varied by 20 or more points in I.Q. upon a second testing.[1]

Another study indicates even less constancy and stability of test ratings for very young children. Dr. Hallowell tested 436 children between the ages of three months and four years, then retested the same children from one to two years later. Although the test ratings remained constant for about half of the children, there was greater variation between the two tests for those children who had first been tested under two years of age than for those first tested between the ages of two and four. Of the entire group of 436 children, 30 per cent did better on the second test while only 17 per cent rated lower on the second test. This finding seems particularly significant, since it suggests that the test results with very young children are more likely to underrate than to overrate their intellectual capacities.[2]

That the greatest inconstancy of test ratings appears in the testing of pre-school children is quite understandable, for it is often very difficult to secure as good coöperation on tests from very young children as can ordinarily be expected from children of school age. Young children are very apt to be either timid and shy or exceedingly negativistic. The negativistic reactions of young children are especially likely to invalidate test results. In one study of 277 pre-school children, negativistic reactions to the tests were prominent between the ages of two and a half and four years, reaching a peak around the age of three, and the children who were negativistic and resistive made a lower mean rating on their tests than those who were less negativistic.[3]

[1] See "Stanford-Binet Retests of 441 School Children," by G. Hildreth. *Pedagogical Seminary*, Vol. 33, pp. 365–86, September, 1926.

[2] "Stability of Mental Test Ratings for Pre-school Children," by Dorothy K. Hallowell. *The Pedagogical Seminary and Journal of Genetic Psychology*, Vol. 40, pp. 406–21, June, 1932.

[3] "Negativistic Reactions of Pre-school Children on the New Revision of the Stanford-Binet," by B. A. Mayer (*Journal of Genetic Psychology*, Vol. 46, pp. 311–34, June, 1935). See also *The Effect of Resistance on Intelligence Test Scores of Young Children*, by M. M. Rust. (Child Development Monograph No. 6.) New York: Teachers College, Columbia University, 1931.

Although the research projects were undertaken in an effort to discover how much mental development may be affected by the child's environment, the data from certain recent studies from the University of Iowa Child Welfare Station suggest that variations in I.Q. upon successive tests may be expected if marked changes in the child's living situation have occurred in the interval between tests.[1]

Certain studies on the variability of the I.Q. indicate that the longer the interval between test and retest, the greater is the probability of variation in I.Q. R. L. Thorndike reports that the tendency toward constancy of the I.Q. decreases as the time interval between tests increases. R. R. Brown states that an interval from five to nine years between two Stanford-Binet tests increases the variability of the I.Q.'s to nearly twice that when the interval between tests is less than two years, and the chances are about 25 in 100 that the I.Q. will vary by more than 15 points when there is a seven-year interval between tests.[2]

In devising psychological tests, the aim was to provide objective and reliable methods of measurement, independent of the subjective judgment of the person giving the tests. But although this purpose was partially achieved through the provision of instructions for giving the tests and crediting success or failure according to well-defined rules, such factors as the personality of the examiner, the background and experience in giving tests and in working with children, and skill in evaluating and interpreting the test results in the light of other information about the child and his reactions during the testing, cannot be excluded from the testing situation. Psychologists, like the members of any other profession, differ individually in native aptitude for their work and in the amount of experience and professional skill that they have

[1] See *A Study of Environmental Stimulation: An Orphanage Pre-school Project*, by H. M. Skeels, Ruth Updegraff, B. L. Wellman, and H. M. Williams. (University of Iowa Studies in Child Welfare, Vol. 15, No. 4, 1939.) See also *Mental Development as Related to Institutional Residence and Educational Achievement*, by Orlo L. Gressey. (University of Iowa Studies in Child Welfare, Vol. 13, No. 1, 1937.)

[2] See "The Effect of the Interval between Test and Retest on the Constancy of the I.Q.," by R. L. Thorndike (*Journal of Educational Psychology*, Vol. 24, pp. 543–49, October, 1933) and "The Time Interval between Test and Retest in Its Relation to Constancy of the Intelligence Quotient," by R. R. Brown (*Journal of Educational Psychology*, Vol. 24, 1933, pp. 81–96, February, 1933).

acquired. In a recent study, it was found that the same child might differ by as much as 30 or more points in I.Q. when tested by two different psychologists, even though the two tests were given within a short period of time.[1]

If the personality and experience of the psychologist who gives the tests sometimes influence the results, it is equally true that the personality and emotional state of the child who is taking the tests may affect the ratings. We have learned, from clinical experience, that when there is an opportunity to retest an emotionally disturbed child at a time when there is less emotional disturbance, the rating on the second test may be substantially higher than on the first one. This point is of such importance that it may well be illustrated by several cases in which the gain in I.Q. upon retesting seems to be related to the change in the child's emotional state.

Our first illustrative case is that of a child of six and a half years who was first tested shortly after he entered school. He was one of those children who find it very difficult to adjust to the partial separation from home and mother that is involved in going to school. This particular boy cried every morning because he did not want to leave his mother and go to school; at night he had dreams about school from which he awakened with fear and in tears. At school he was often tearful, and did not seem to comprehend any of the first-grade work, so that the teacher raised a question as to his intelligence and referred him to the school psychologist for tests. When he was tested, in the state of emotional stress described above, he made an I.Q. of 79. He was then placed in a special class.

Two months after the placement in the special class, the boy had become better adjusted to the separation from his mother and had even begun to like school. His nightmares had ceased and he was beginning to learn the school work. The special-class teacher felt that he was, in fact, learning at a rate that would be expected of a child of good intelligence. It was at this time that he was brought to the clinic for retesting. He made an I.Q. of 97, which confirmed the special-class teacher's impression that the results of the first tests had been

[1] See "Stanford-Binet I.Q. Variations," by Psyche Cattell. *School and Society*, Vol. 45, pp. 615–18, May 1, 1937.

affected by the emotional disturbance he was undergoing at the time when he had taken them.

Another illustration is the case of a boy who was brought to the clinic for treatment because of many emotional and personality problems. He was the only boy in a family of girls. His father had died when he was a baby, and thereafter the mother had become very protective of this boy. She did not allow him to enter school until he was seven years of age, but kept him closely at home and permitted him to play only with his sisters. Even after he was in school, his mother still insisted that he play with his sisters because she considered the other boys in the neighborhood too rough and dangerous as playmates for him. The boy made a very poor adjustment to school. He could not compete with the other boys in games and was called a "sissy." He often complained of being sick during school hours, refused to eat lunch, and asked to go home. He was not able to do any of the work. At the age of nine, after two years in school, he had only reached second grade, after having spent three terms in first grade. He was then referred to the school psychologist for testing, and made an I.Q. of 79. He was transferred to special class on the basis of this low I.Q. and the history of poor school progress.

A year later, when he was ten years old, his mother brought him to the clinic for treatment, complaining that he still was not learning at school, even in the special class, could not get along with the other boys, was very effeminate, and was suffering from enuresis. There was an eight-months period of treatment with the boy and case-work with the mother. During treatment, the boy changed from the fearful, inhibited, passively feminine kind of personality that he appeared to be when first seen at the clinic. He became more aggressive in his behavior and more masculine in his interests. He played with other boys and no longer had enuresis. His mother had stopped restricting his companionship with other boys. At this time, he was retested at the clinic, and made an I.Q. of 99, which was 20 points higher than the I.Q. of 79 on the tests given elsewhere twenty months before.

There was as great a difference in his responses to the two tests as in the I.Q. ratings. At the time of the first test, he was described as slow in all his responses, unable to express

himself well, lacking in initiative and energy. At the time of the second test, he was rapid in his responses, energetic, expressed himself freely, and seemed mentally alert and possessed of an ordinary amount of initiative. The change in his responses at the time of the second test obviously corresponds to the change in his personality that took place through the treatment. However, at the time of the second testing, it was discovered that he had a severe reading disability and would need remedial teaching in that subject before he could be expected to make any normal progress in school.

The low rating on the first test, the reading disability, and the continued failure in school, all seem quite explicable on the basis of the boy's serious emotional problems and his personality difficulties. Yet at the time of the first testing by the school psychologist, it was only natural that his low I.Q., his slowness and seeming dullness in responses, and his school failures should be interpreted as evidence of mental deficiency. Even for the most experienced psychologist, it is not always easy to judge whether a low I.Q. and retarded responses are due to mental deficiency or whether the child is emotionally inhibited or resistive to the testing.

Since there have been studies that indicate some tendency for test results to vary when the testing is done by different psychologists, the question might be raised as to whether this may be the chief factor in the variation of I.Q. in the two cases just described, rather than the emotional state of the child at the time of the tests. We can answer this question only inferentially by data from cases in which this factor of the influence of different examiners is ruled out. Similar changes in I.Q., with changes in the child's emotional state, appear when the tests are repeated by the same psychologist.

Take the case of a child first tested at the clinic when he was three years old. He was then resistive and negativistic, throwing the test materials around the room or trying to destroy them, and it was difficult to secure any coöperative response from him. His negative, destructive reactions were greatest, however, at the start of the testing, when his mother was in the room. After she left him alone with the psychologist, he was a little more coöperative, but even so he made an I.Q. of only 70 on the Kuhlmann-Binet. However,

this rating could not be accepted unreservedly as evidence of mental retardation, since the boy's responses indicated that it might well be his resistiveness, rather than lack of intelligence, that was responsible for his making a low I.Q.

Although the boy's mother complained that his behavior at home was as destructive, negativistic, and disobedient as his behavior in the testing situation, she did not care to consider treatment for him at that time. Four years later, she brought him back to the clinic for treatment. He was then seven years old, and was doing very well in the second grade at school, so that his teachers had no complaint about his behavior, but at home with his mother he was as disobedient, rebellious, and negativistic as ever.

Before treatment was started, the boy was retested. He worked well and coöperatively on the tests and made an I.Q. of 105, which was 35 points higher than the I.Q. of 70 obtained when he was tested at the age of three. At the time of the first test, he had apparently responded to the psychologist with the same negative, destructive attitudes that he had toward his mother at home, but when he came for the second test, he responded coöperatively to the psychologist as he did toward his teachers at school. These differences in his attitude toward the psychologist probably accounted for the difference in the I.Q. ratings.

In the case just described, the possible factor of influence of different examiners upon the test results is excluded, since the two tests were given by the same psychologist. But in view of studies which indicate that when the first testing is at a very early age, there is greater probability of variation in I.Q. in retesting, and other studies which suggest that a long interval between test and retest increases the probability of a marked change in the I.Q., there might be a question as to whether the fact that this child was three years old at the time of the first tests and seven years old at the time of the second tests should be considered significant in explaining the divergent I.Q. ratings. However, our emphasis on the significance of the child's attitudes toward the testing is in accord with studies of negativistic reactions of young children to testing, which indicate the tendency of such reactions to result in lower test ratings. In this particular case extremely

negativistic responses were prominent during the first testing, so that it seems that the more probable explanation of the 35-point difference in I.Q. is the change in the boy's attitude toward the psychologist and the testing situation, rather than the age at which he was first tested or the four-year interval between the two tests.

In the next two case illustrations, all such factors as different examiners, a long interval between tests, or testing at a very early age are excluded, for the testing was done by the same psychologist, the children were beyond pre-school age, and the time interval was fourteen months in one instance and four months in the other.

The first of these cases was a boy who came to the clinic at twelve years of age because he was in trouble over truancy from school. His truancy began when he entered sixth grade and at the same time was transferred to a new school. His own explanation of his truancy was that he stayed away from school because he feared the other boys, who teased him about his foreign accent and mannerisms and "beat him up" when he tried to fight them in outbursts of anger at their teasing. He could not go to school because he feared these boys, he stated, but he was worried about staying away from school lest he be sent to a reformatory as a punishment for truancy.

While the boy was, by his own admission, in this state of conflict about his school situation, he was given tests at the clinic. On the old Stanford-Binet, he made an I.Q. of 87, and the Stanford achievement tests gave him only a fifth-grade score, although he was in sixth grade at school. These test ratings raised the question whether inferior intelligence and inability to do sixth-grade work might be contributing to his truancy. But there was also a question as to whether the I.Q. could be considered reliable as a measure of the boy's real intellectual ability, since he had taken the tests under great emotional stress. He had constantly interrupted the tests to talk about his worries, and had even said that he would run away from home or kill himself rather than go back to school, where he would be at the mercy of the other boys or run the risk of being sent to a reformatory because of his continued truancy. With his mind so full of his personal feelings and problems, there was a possibility that he was

unable to give sustained attention to the testing and that he obtained a low I.Q. because he was unable to work efficiently rather than because he was actually dull. There was also a question whether the low educational-achievement test scores were due to intellectual limitations which prevented him from mastering the work of his school grade or whether his failure to master the sixth-grade work was a result of having missed a part of it through his continual truancy and his inability to concentrate upon it when he was in school, because of his preoccupation with his own problems.

These diagnostic questions could be answered only later, when he could be retested under more favorable circumstances. Meanwhile, a way out of his unhappy situation was offered him through the opportunity to go to a boarding school for truant boys. Although some boys took being sent to this school as a punishment, this boy was eager to go. In his first year there, he did so well in his school work that retesting was requested, to determine whether the first tests had been inaccurate.

Fourteen months after the first tests had been given, the boy returned for retesting. He was alert, cheerful, and able to concentrate on the tests, working very efficiently. He made an I.Q. of 113, when the old Stanford-Binet was repeated. This I.Q. was 26 points higher than the I.Q. of 87 on the earlier test. On the Stanford achievement tests, he made an eighth-grade score, whereas on those tests fourteen months previously he had made only a fifth-grade score.

The boy's own words, at the time of the second testing, indicate how differently he was feeling than at the time of the first tests, when he was talking of running away from home or of suicide as an escape from what seemed to him an intolerable situation. After being told that he had done much better on the retesting, he stated that he had expected to do better because this time he could keep his mind on the tests.

"When I took the tests before," he said, "I just couldn't keep my mind on them. That was when my father was trying to make me go to school and I couldn't go because I was so afraid of the other boys. I like boarding school. I get along all right with the boys there. I can keep my mind on my work now."

It may be of interest to add that after the boy had had another year at the boarding school for truant boys, he returned home and attended high school, doing satisfactory work and graduating in the usual length of time.

The second case of this kind was that of a boy who was brought for treatment at the age of eight and a half years. He had been excluded from school after two years in the first grade. He had not been able to learn any of the work and had disturbed the class by his restlessness. He had never played voluntarily with the other children and if a supervising teacher made him join their games, he retreated from play as soon as this supervision was relaxed.

When first seen at the clinic, he looked, talked, and acted so much like a mentally deficient child that it seemed advisable to give him tests. It was surprising to have him make an I.Q. of 84 on the old Stanford-Binet, since this rating ruled out the possibility that he was mentally deficient. In the treatment interviews immediately following the testing, it became evident that he was a repressed, inhibited, fearful child, who was afraid to undertake any activity, even play.

Burnham calls this kind of child "pseudo-feebleminded," and states that such a child resembles a mentally deficient child in behavior, but is shown by adequate tests not to be actually mentally deficient. Burnham further states: "One of the most serious causes of pseudo-feeblemindedness is the inhibition of fear."[1] Anna Freud describes such children as neurotically inhibited, with severe restriction of ego activities. She speaks of them as intelligent, but not taking part in the regular games or lessons and behaving as if they were intimidated.[2]

Whether we use Burnham's concept of pseudo-feebleminded-edness due to fear inhibition or Anna Freud's of neurotic inhibitions with restriction of ego activities, as a diagnostic classification for the boy in our case, the fact remains that at the time he came to the clinic, he was afraid to do anything, even to play. After four months of treatment, during which time he was seen two hours weekly, he was learning to read and to do arithmetic with a private tutor, was playing in a

[1] See *The Normal Mind*, by W. H. Burnham. New York: D. Appleton and Company, 1924. Chapter 18.

[2] See *The Ego and the Mechanisms of Defence*, by Anna Freud. London: Hogarth Press, 1937. Chapter 8.

normal manner with other children in the neighborhood, and no longer looked or acted like a mentally deficient child. He himself spoke of how he had been afraid of people when he first came to the clinic and said that he was glad he was not afraid any more. Preparatory to his return to school, the Stanford-Binet was repeated, in order to secure an up-to-date report for the teachers.

In this retest, at the end of his four months of treatment, he made an I.Q. of 99, which was 15 points higher than the I.Q. of 84 on the first test given at the beginning of treatment. This I.Q. of 99 rated him as of normal intelligence. When he was told that he had done better on the second test than on the first, he spontaneously offered the explanation: "When I first came, I was afraid to talk to you, so I didn't answer as many of the questions."

When the Stanford-Binet was first made available in 1916, Terman stressed the necessity of giving intelligence tests in a quiet room, without distracting influences, and stated that the presence of other persons was one of the most disturbing influences. Terman was indeed so definite on this point as to say:

> "If accurate results are to be secured, it is not permissible to have any auditor, besides possibly an assistant to record the responses. Even the assistant, however quiet and unobtrusive, is sometimes a disturbing element. . . . If the examiner is experienced, and if the child is not timid, it is sometimes possible to make a successful test in the presence of a number of auditors, provided they remain silent, refrain from staring, and otherwise conduct themselves with discretion. But not even the veteran examiner can always be sure of the outcome in demonstration testing."[1]

This warning as to the unreliability of tests given in the presence of observers is not always heeded, and on the basis of an I.Q. obtained under such unfavorable circumstances, a child is sometimes diagnosed incorrectly. Our last illustrative case shows what the response of a sensitive child may be when examined in the presence of observers.

A mother came to the clinic asking for help with her twelve-year-old son. He was not doing well in school and had become somewhat of a behavior problem. The school was suggesting that she send him to a school for mentally retarded and problem children. Two years before, the boy had been tested at a hospital clinic and had obtained an I.Q. of 78, and a diagnosis

[1] See *The Measurement of Intelligence*. Chapter 8.

of border-line mental deficiency had been made and reported to the school. A group of students had been present as observers during the testing and afterward the boy had complained about how nervous their watching him had made him. When the mother suggested returning to the hospital clinic for another test, the boy refused; his memory of his previous visit made him feel that it was an ordeal too painful to be repeated. His mother thought that she could persuade him to go to a different place, however.

Knowing of the boy's unpleasant and painful experience with testing, it was possible to plan for a few informal interviews with him before any retesting was done. In these interviews, he was able to talk about his feelings with regard to coming to another clinic, after his past experience, and also to enter into a somewhat positive relationship with the psychologist. The necessity of repeating the tests was explained to him realistically in terms of what school plans could be made for him. He agreed to take the tests again, but he spent the rest of the interview in talking about his feelings at the time of his first testing two years before.

The clinic to which he had gone then was at a hospital where "crazy" people were kept. He had not liked the place and had hated to go inside. There had been a lot of "doctors" around, watching him do the tests, and finally he had felt so nervous and angry that he would not answer any more of the questions, but had just said he didn't know, whether he really knew the answer or not. He supposed that had caused him to get a poor mark on the test, but he had not cared about that—he had only wanted to get out of the place, and he had thought that he could get out quicker by saying that he didn't know instead of answering any more questions.

In spite of having said that he would be willing to take the tests again, when it came to the actual testing, he was resistive. Soon it became necessary to interrupt the testing to have him talk further about his feeling with regard to it. When the psychologist said that he probably felt angry at being made to take the tests, just as he had felt angry when he had had to take them before, he replied that it did remind him so much of the first time he had them that he felt angry all over again. But he would try to do the tests this time, he added.

He then worked very well until the tests began to be somewhat difficult for him, when he began to hesitate in his replies and to confuse the instructions for one test with those for another. Again the tests were interrupted while it was suggested that perhaps he was afraid that he might not be able to do any better than he had on his previous tests and was worrying about that. He replied that he was very much worried about it. He was informed that he need not worry; he had already done enough of the tests to make a higher score than the one he had made before. Thus encouraged, he put forth good effort again and was able to work efficiently until the tests were completed. In contrast to the I.Q. of 78 which he had made two years before, when tested in the presence of observers, he now made an I.Q. of 100, which classed him as of normal intelligence.

He was so pleased to find that he was not "dumb," as he called it, that he was eager to continue interviews at the clinic, and became optimistic about succeeding in school work in the future. The tests had revealed not only that he was of normal intelligence, but also that he had a slight reading disability which was handicapping him in his school work. He was transferred to a school where he received special instruction in reading. He made good use of his treatment interviews at clinic and of the special teaching at school, so that within a few months he was doing much better in his school work than ever before and there were no longer any problems so far as his behavior was concerned. The treatment was terminated, with his agreement, at this time.

He came back for single visits toward the end of each school year for the next three years. When he came for the first two visits, he was worried about passing the final examinations for the year, but could see that this anxiety was because of his past experiences in failing. At the end of the third year, he came without any anxiety, reporting that he had just passed the year's final examinations successfully. He had wanted to make this visit in order to express his thanks for the help he had received at the clinic, he explained. He has not asked for a visit in the two years since that time, so that in expressing his gratitude he was also apparently severing his connection with the clinic, feeling no further need of even occasional support.

It is impossible, within the scope of a single paper, to describe the large number of tests now available, or to survey all the literature that has a bearing upon the use and interpretation of tests. It has been necessary, therefore, to limit the discussion to those tests most frequently used in our own clinic, to report only samples of studies in the literature, and to draw upon clinical experience for individual case material to illustrate some of the important points to be considered in the use and interpretation of psychological tests.

Psychologists have devoted considerable research to the question of the reliability of psychological tests. Outside of the psychological profession, the evaluation of tests often seems to be largely a matter of personal opinion, with an all-or-none attitude. The results of tests tend to be accepted too unquestioningly by some, while others have considered them of little if any value. The truth seems to lie somewhere between these two extremes, for tests are reliable in the majority of cases, and it should be possible for the experienced examiner to evaluate the situation in individual testing so as to detect many of the cases in which there is sufficient question as to the reliability of the test results to make retesting advisable at a later time before giving anything more than a tentative diagnosis, or even before giving any diagnosis at all.

If we are thus cautious about interpreting test results for diagnostic purposes, it follows logically that we are also cautious about making any prognosis. We have indeed departed from the original concept, in the early years of testing, that the chief usefulness of tests was to classify the child in some category that could be expected to remain fixed and permanent and to furnish a basis for prediction of the child's development for his whole life span. We may say, instead, that the most valuable and the most legitimate use of tests is as a measurement of the efficiency of the child's mental functioning at any given time, with the realization that at another time, with the changes that may have occurred within the child or in his living situation, the same tests may show more or less efficiency in his mental functioning, depending upon whether the changes in his life have been favorable or unfavorable for his growth and development.

THE MINNESOTA "SEXUAL IRRESPONSIBLES" LAW

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ON February 26, 1940, the Supreme Court of the United States held valid a Minnesota law which provided, in effect, that persons who are irresponsible for their sexual conduct and therefore dangerous to others may be committed as if insane. The first reaction to this decision may well be anxiety over the possible harmful consequences of the enforcement of so far-reaching a statute. On further consideration, the act may seem a praiseworthy effort to substitute public medical care and treatment for punishment by penal servitude. Thereafter considerable question may arise as to whether the beneficial effects of such a law will outweigh the dangers.

The question is of interest to all who meditate on the weakness of the flesh, and intellectual appreciation of the court's assurance of adequate protection and limitation of application will not, of course, fully discharge the emotional content of such meditation. It will be felt that while this law may be applauded as an effort to speed up slow-moving democratic government, the question of its constructiveness cannot be definitely answered until sufficient time has elapsed for evaluation of its net results.

The statute contains (in Section I) the following definition of the persons to whom it applies:

> "The term 'psychopathic personality' as used in this act means the existence in any person of such condition of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of any such conditions, as to render such person irresponsible for his conduct with respect to sexual matters and thereby *dangerous to other persons.*" [Italics mine.]

This definition was interpreted by the Supreme Court of Minnesota in the following language:

> "Applying these principles [of statutory construction] to the case before us, it can reasonably be said that the language of Section I of the act is intended to include those persons who, by a habitual course of misconduct in sexual matters, have evidenced an utter lack of power to control their sexual impulses and who, as a result, *are likely to attack or otherwise inflict injury, loss, pain or other evil on the objects of their uncontrolled and uncontrollable desire.* It would not be reasonable to apply the provisions of the statute to every person guilty of sexual misconduct nor even to persons having strong sexual propensities. Such a definition would not only make the act impracticable of enforcement and, perhaps, unconstitutional in its application, but would also be an unwarranted departure from the accepted meaning of the words defined." [Italics mine.]

On this basis the Minnesota court held the statute valid,[1] and an appeal was taken to the Supreme Court of the United States.[2]

The points of objection dealt with by the court were: (1) that the act is too vague and indefinite to constitute valid legislation; (2) that the act denies equal protection of the law as guaranteed by the Fourteenth Amendment of the Federal Constitution; and (3) that the act denies due process of law similarly guaranteed.

As to the first objection, the court said that it was bound by the construction placed on the statute by the Minnesota court (as above set forth) and that such construction disposes of the contention that the act is too vague and indefinite to constitute valid legislation. The court expressed the view that the underlying conditions enumerated by the state court "are

[1] State ex rel. Pearson v. Probate Court of Ramsey County *et al.*, 205 Minn. 545; 287 N. W. 297. According to a press account, the person involved was a fifty-three-year-old man who had been married since 1911, and who was accused by a number of girls, ranging from thirteen to fifteen years of age, of taking liberties with them. The police said that numerous young girls had been loitering in his sheet-metal shop and that he had made a practice of taking them riding in his automobile. The statute was approved by the governor on April 21, 1939 (Ch. 369, Laws of 1939; secs. 8992–184a—8992–184d, 1940 Supplement to Mason's Minneapolis Statutes of 1927) and on the sixth day thereafter a police officer signed a petition, which, as provided by the act, was approved by the county attorney, and a hearing in the probate court was set for May 5. Pearson petitioned the Supreme Court of Minnesota for a writ commanding the probate court to desist from proceeding against him under the act, and, upon an adverse ruling by the court, he appealed to the Supreme Court of the United States.

[2] No. 394. October Term, 1939.

as susceptible of proof as many of the criteria constantly applied in prosecutions for crime."

To the argument that the statute denies equal protection of the law, in selecting a group that is a part of a larger group, the court answered that there is a rational basis for the selection, since the class to which the statute applies "is identified by the state court in terms which clearly show that the persons within that class constitute a dangerous element in the community which the legislature in its discretion could put under appropriate control."

As regards the objection to the procedural aspect of the act, the court ruled that there was no defect apparent on its face; it stated that the "laws as to proceedings where persons are alleged to be insane are made applicable," and assumed that "the Minnesota courts will protect appellant in every constitutional right he possesses."

For all practical purposes, this decision is a complete answer to the question whether this Minnesota law is constitutional, but it should be noted that the objections passed upon were those directed at the wording of the statute itself as interpreted by the state court, and that this may not necessarily be the last time a question arising out of this law will receive the attention of the Federal high court. For example, a question may arise whether, in the case of a particular individual who has been ordered to be committed, certain sexual conduct is or is not within the definition contained in the statute as interpreted by the Minnesota court; or whether the individual is or is not within the class of persons defined as "a dangerous element in the community"; or whether the particular application of the law is inconsistent with constitutional guarantees of due process of law.

With reference to the second of these possible questions, the following words of the court are of interest: "We should not adopt a construction of the provision which might render it of doubtful validity . . . in advance of a decision by the state court applying the statute to persons outside that definition." And as to the third possibility, the court said: "But we have no occasion to consider such abuses here, for none have occurred. . . . and we should not assume, in advance of a decision by the state court, that they should

be construed so as to deprive appellant of the due process to which he is entitled under the Federal Constitution. . . . His procedural objections are premature." The court also stated: "These various procedural questions, and others suggested by the appellant, do not appear to have been passed upon by the state court."

This decision by the highest court of law in the United States is significant in many respects, but probably its greatest importance to mental hygienists is the fact that it provided the setting for recognition of a connection between the sphere of sex and that of mental health. This decision will undoubtedly be the cause, directly or indirectly, of study by a wider group of this important and complex linkage. On the other hand, there is the possibility that it may result in similar action by other states before experience under the Minnesota law has proved the wisdom of this method of approach.

Notwithstanding the approval given to the act by the highest Minnesota and United States courts, the state agencies charged with its enforcement are bound to face considerable difficulty in administering it. The act itself, it must be admitted, is very broad as regards the type of sexual irresponsibles the drafters of this legislation sought to guard against; and, while the Minnesota court restricted the statutory definition by including the elements of habitualness and likelihood of "attack," "injury," "loss," "pain," or "other evil," it could be countered that it is the very nature of an instinct to follow a habit pattern, that the element even of "attack" might conceivably be difficult in some instances for the parties themselves to determine, and that at best it might be a question of the unsupported word of one person against that of another.

To illustrate the vagueness of the law in the matter of the type of sexual delinquent with which its proponents intended it to deal, it might be mentioned that the present author first understood the language of the act and of the two court decisions as referring exclusively to those "untalkables" who are more sinned against than sinners—the homosexuals—particularly since the Minnesota court had incidentally referred to the individuals subject to the law as

"unnaturals."[1] However, if there be any substantial validity to a contention that the act might be interpreted as applying to homosexuals as well as to those who are liable to attack children, there would be even greater possibility of the presentation to county attorneys and probate judges of cases involving persons whose conduct was less unusual, but still not acceptable according to our present-day code of sex morality. One may even consider the possibility of the commitment of adolescents or children of tender age under this law.

Almost inextricably bound up with the question who are subject to the law, is the query what type of sexual conduct makes one subject to commitment to a hospital for the insane under this act. The law does not state (and it cannot therefore be assumed) that the statute applies only to conduct that is prohibited by the criminal law, and even if the criminal statutes are taken as the criteria, attorneys and judges are placed in an unenviable position. For example, the Minnesota law includes in its definition of rape relations with a female whose resistance is prevented by stupor or by weakness of mind produced by intoxicating, narcotic, or anæsthetic agents administered by or with the privity of the defendant, or when such female is unconscious of the nature of the act and this is known to the defendant. What would be the attitude as to enforcement in such cases, and in the case of other conduct prohibited by the Minnesota statutes as follows: compelling a woman to marry; abduction for the purpose of prostitution or sexual intercourse; indecent assault not amounting to rape; bigamy; incest; the crimes against nature grouped under the one term "sodomy," in which both the aggressive and the submissive person are made punishable and in which, apparently, the fact that the two persons may be married to each other would be no defense; adultery, defined by the law as intercourse between a married woman

[1] It would require but little stretch of the imagination to visualize attempts to bring into court for indefinite commitment these ordinarily harmless persons. The main argument against the possibility of interpreting the act as applying to this class of sexually irresponsible person is the aspect of "attack," "injury," "loss," "pain," or "other evil," which has been made a requirement by the state court; but, as one interpretation often gives rise to the necessity of others, this act may be made applicable to homosexuals, depending upon the definition given to these words.

and a person other than her husband; fornication, described as intercourse between a single woman and any man; seduction under promise of marriage; and cohabitation with a boy under the age of eighteen? When we consider the layman's view of what the law is, the fact that some of the "victims" of dangerous sexual conduct or sexual assault may not be victims in the true sense of the word, and the general emotional upheaval incident to cases of sex delinquency, it would be difficult to say that the decisions of the two courts are a complete guide to enforcement of the statute.

There can be no doubt that this law will be viewed with apprehension by those who have studied at close range the difficulties, conscious or unconscious, caused by sex repression in the classes of person usually described as neurotic, psychopathic, or psychotic. They will grant that some of the individuals subject to the law—such as paretics in whom disease organisms have caused actual damage to the brain and nerve tissue—would eventually be institutionalized under the regular commitment law, but in the case of other nonconformists to the usual sex pattern, they will weigh in the balance the degree of protection offered to society against the harm that may be done to the individual. In other words, is the legislation necessary or is it premature?

As indicated in my opening paragraph, the legislation could be viewed in its patent aspects as a laudable effort to treat rather than to punish the mentally ill, but what about the possibility of a latent or unconscious effort on the part of the drafters to punish for conduct that might otherwise be unpunishable, or at any rate not punishable by life confinement? What, it may be asked, will be actually accomplished under this law for the protection of society or of the persons who may be committed? Unless the situation as regards hospitals for the mentally ill is much better in Minnesota than in many other states, it is unlikely that much in the nature of therapy will be accomplished for the persons placed therein, possibly for the rest of their lives; and, on the other hand, irreparable injury and tragedy to them may result.

We should also take into consideration the possible psychic trauma of the commitment procedures to the very individuals whom the law is intended to protect, since, generally speaking,

the most harmful and lasting effects of sexual assaults on children are psychological, and they may have indelibly stamped on their young minds the impression that sex is inherently evil if it can cause commitment for life; intellectual understanding as to the line between socially acceptable sexual conduct and that which is tabooed may be dimmed by the emotional component.

One of the strongest arguments in favor of amendment or repeal of this law is that it is simply another law added to that group of statutes which are a constant threat to society as a whole without adequate gain. This is true whether it is strictly enforced or is allowed to become obsolete through difficulties of enforcement. (For example, a state statute is said to be still in force that makes a criminal offense of going to church unarmed.) Under this law commitment is not necessary to ruin a person's reputation or his ability to earn a living; submission of facts relative to his "conduct" to the county attorney and preparation of a petition might well suffice.

Beyond that, the fact must be faced that the law does place a great responsibility on county attorneys and probate judges, notwithstanding the fact that it directs the appointment of two "duly licensed doctors of medicine to assist in the examination of the 'patient.'" No jury is required to pass on the facts and even on an appeal to the state district court, judgment may be granted on the pleadings and without a jury determination. It is true that further appeals to the state and Federal supreme courts are available, but, as a practical matter, how many persons will be financially able to prosecute such appeals? Moreover, in passing upon appeals, such courts consider only questions of law and do not pass on the weight of the evidence. Probably the most difficult problem for attorneys and judges in these cases will be that of deciding when the sexual irresponsibility is caused by "emotional instability," "impulsiveness of behavior," "lack of customary standards of good judgment," or "failure to appreciate the consequences of his acts," and when it is due to other factors. Even casual meditation should convince them that, with all due respect to the doctrine of free will, the so-called causes of the sexual behavior or outbursts in these

cases are in turn caused in great measure by every incident and element in a person's surroundings since his birth as well as by hereditary factors.

The law grants to county attorneys and judges of probate courts tremendous power over any man (or woman) who has been so indiscreet as to fondle or otherwise mishandle a little girl (or boy), particularly since the act authorizes the exclusion of the general public from the hearing and, as heretofore stated, no jury is required to pass upon the facts. The trial in open court by a jury of one's peers is a bulwark of our democracy, and the passions that will be loosed on these sexual deviants will be markedly different from the attitude in regular insanity cases, in which trial by jury is generally held to be unnecessary. We are treading on dangerous ground when, by considering a certain proceeding as an inquiry into behavior instead of the trial of a criminal charge, we dispense with the constitutional safeguards of our liberty.

Again, the offices of county attorney and probate judge—which, incidentally, do not require bar membership or even law training as a qualification—are elective. The incumbents are elected as members of a political party, so that in addition to the danger of the possible *inability* of county attorneys and probate judges to do justice in these cases, there is the element of actual malice to be considered. It is indisputable that such persons are subject to human frailties, and even the most stable individual is likely to experience some rise in emotionalism when brought face to face with a case of sex delinquency, with a consequent beclouding of intellectual and ethico-moral appraisement. Moreover, it must be remembered that the matter to be decided is not that of a single fact—*i.e.*, whether the person did or did not do a thing prohibited by law—but the question what was his conduct, including in that conduct *likelihood* of "danger," "attack," or otherwise inflicting "injury," "loss," "pain," or "other evil."

Some months ago there appeared in a popular magazine an article by a famous Canadian physician commenting on the trend away from nature in modern living. To carry this doctor's idea a little further, is it not possible that the further mankind gets away from nature, the more artificial life

will become, and that, as a result of such artificiality, there will be an increase in so-called abnormal behavior, including, of course, gratifications of the sex impulse?[1] It is inherently difficult to be scholarly or to avoid the appearance of popularization in dealing with the matter of our cultural insistence on sex repression. Moreover, any one who seems to be condoning abnormal sex behavior in any way may be suspected of indulging an unconscious defense mechanism. But these considerations are small excuse for avoiding the duty of discussing the many implications of this subject. Such discussion must of necessity be largely conjectural, since it would be practically impossible to present case material on all the phases of the subject. However, it is a well-established principle of law that the courts will take judicial notice of certain facts without the necessity of proof; and many of the aspects and patterns of human conduct are such as to warrant such notice of the serious consequences of society's insistence that men and women must conform to a standard code of sexual activity.

Those who may look with disfavor on this law must—and undoubtedly do—admit that the repeating sex offender is a serious problem[2] and that governmental agencies cannot ignore the demand that something be done to solve it. What is required is an unemotional approach, to determine whether legislation such as this or some other expedient is the solution. It is ridiculous, of course, to expect that any plan will be a complete success, but somehow there comes to mind as worthy of consideration in this connection the concluding idea of Bernard Hart in his work on insanity: "It is possible that insanity, or a part of insanity, will prove to be less dependent

[1] The writer recently participated in the seminar on human biology offered by the Washington School of Psychiatry. The theories there unfolded as to the stages of personality development and the sexual components therein have profoundly affected his views on this subject.

[2] For an excellent discussion, see "The Challenge of Sex Offenders," a symposium presented at the Twenty-eighth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 10, 1937, and published in MENTAL HYGIENE, Vol. 22, pp. 1–24, January, 1938. The participants were Edward A. Strecker, M.D., Professor of Psychiatry, University of Pennsylvania; Honorable Austin H. MacCormick, Commissioner of Correction, New York City; Karl M. Bowman, M.D., Director, Psychiatric Division, Bellevue Hospital, New York City; and Winfred Overholser, M.D., Superintendent, Saint Elizabeths Hospital, Washington, D. C.

upon intrinsic defects of the individual than on the conditions in which he has to live and the future may determine that it is not the individual who must be eliminated, but the conditions which must be modified."[1]

The presence in society of these maladjusted persons is, indeed, a challenge, and further investigation and research are clearly indicated to determine in what manner the threat may best be met.[2] The first step, of course, must be the education of public opinion by the method that has been so successful in the case of venereal diseases—that is, by stressing the amoral and medical aspects of the problem. It can be done, as is evidenced by the recent change in attitude on the subject of venereal diseases.[3] The cause of the reluctance of the public to face unemotionally the problem of venereal disease was identical with that at work in the present problem—sex. We are far from accepting and acting upon the basis that understanding all is forgiving all, but until we do understand more about the sex offender's problem and the problem of the sex offender, governmental efforts must continue to be those of scaring, shaming, condemning, or eliminating, and these efforts will, as always, be supplemented in a certain proportion of cases by mob violence. The adoption by the Minnesota Senate (on the same day that it passed this law) of a resolution that a committee be appointed by the state medical association and the state bar association to make a study of the subject of psychopathic personalities, is therefore very encouraging. Also, it is in just such non-local problems that the National Conference of Commissioners on Uniform State Laws can be of inestimable value, through their study over a period of years—as distinguished from the hurried, emotional,

[1] From *The Psychology of Insanity*, by Bernard Hart. Fourth edition. New York: The Macmillan Company, 1931.

[2] For an instance of constructive disposition of a case involving a homosexual, see "The Courts and Psychiatry," by Ralph M. Crowley, M.D., (with a note by the present writer) in *Psychiatry*, Vol. 1, pp. 265–71, May, 1938.

[3] Only a few years ago the word "syphilis" was not mentioned in polite society and was barred from the radio, whereas, on February 1, 1939, there was witnessed the fine spectacle of the First Lady of the Land discussing this subject before an unabashed luncheon audience in the crowded dining room of a fashionable Washington hotel, on the occasion of the presentation to Surgeon-General Parran of the William Freeman Snow award for his outstanding work in this field. Even further progress is evidenced by a recent motion-picture release in which the discovery of the cure for this dreaded disease is dramatized.

and politically tinged deliberations of legislative committees and bodies—of the many ramifications of such revolutionary legislation as this Minnesota act.

Protect our innocent children we must, but we should hesitate before adding "at any cost," because a certain price might be too high. More research and the training of larger numbers of men and women who are willing and anxious to devote their lives to study are urgently needed in dealing with this problem as with many others that now face mankind.

Such scientists would undoubtedly locate within increasingly narrower limits the sources of contamination of the river of life; and the world would probably be surprised to learn from them how much crime, alcoholism, drug addiction, prostitution, self-destruction, marital failure, unhappy celibacy, economic distress, social and political unrest, and "physical disease" are caused by psychological maladjustment, and how much of this maladjustment flows from the way in which society handles the problems that arise from the instinct known as sex.

Until there is agreement of a larger group than at present as to the efficacy of legislation such as this Minnesota statute, we should proceed slowly, remembering that each additional piece of unenforceable legislation reduces in some measure the dignity of government and is a further impetus toward disrespect for law.

ADULT EDUCATION AS PROTECTIVE MENTAL HYGIENE *

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MENTAL hygiene is usually considered to be concerned with the individual personality, but its function is social since personality has meaning only in social relationships. Its greatest value lies not in the field of therapy, but in that of prophylaxis. It serves peoples as well as people, nations as well as individuals.

Adult education is one of the tools of mental hygiene, an instrument for public health. In the words of Monroe, the historic meaning of education is "a definitely organized institutional attempt to realize in individuals the ideals controlling a given people." As defined by Thom, mental hygiene is "a state of mind which permits an individual to approach his maximum of efficiency and to attain the greatest amount of happiness with a minimum of friction."

Adult education tends to unify these two seemingly conflicting ideas and goals. It becomes in part an integrator of personal and communal values. It derives rich meaning through facilitating the security mechanisms of the individual and of the state. All adult education has as one of its objectives the attainment of personal and cultural security. As Kardiner has said: "Each culture faces its own external anxieties and creates its own specific intrasocial anxieties and emotional anxieties and pressures; the defenses of security systems depend upon (a) what anxieties the society mobilizes and (b) what specific possibilities for advance that same society offers." [1]

As society determines its weaknesses, it becomes necessary to marshal its assets. If personal liberty is threatened in a

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[1] "Security, Cultural Restraints, Intrasocial Dependencies, and Hostilities," by A. Kardiner. *The Family*, Vol. 18, 183–96, October, 1937.

land where liberty is a goal, society must promote personal adaptability to every possible limitation of satisfaction and to the frustration of ambitions. Adult education interpreted as the dissemination of knowledge may enrich the per capita mental storehouse of a community, but its social values inhere in the effect of total application, industry, and interest upon an externalization of personal goals sufficient to offset the emotional pressure incidental to social stress. The mental-hygiene aspect of the adult-education program broadens the base of personal belief in self and reflects, through social activity, some degree of the internalized balance of personal-social emotional values.

Every individual must learn to function as an organism in a family setting, but for general social living. Education is not limited to schools, but permeates life. The mental-hygiene protective component in adult education has a three-fold function: (1) to protect the self against quicksand shiftings of ego values; (2) to develop communal relationships around sound social patterns; and (3) to encourage a conscious willingness to adjust to societal change. All mass education is impersonal, and therefore only as adult education loses its impersonality does it become specifically protective to the individual and to society. Adult education as a social undertaking possesses social values, as well as those regarded as satisfying personal needs.

Rational mental hygiene lessens the hazards of discontent and tends to offset any vague, but threatening sense of insecurity. Adults frequently suffer from an uncertainty of self and a feeling of insecurity that are related to the self's status in the competitive economic field. They struggle against fearful doubts concerning their part in a program of national coöperation. They search for certainty when it appears to be lacking in the world about them. The levels of human aspiration are generally out of harmony with the traditionally permitted outlets of emotional enthusiasm. Man's freedom may be partially guaranteed through his limitations. He is free to do only what he may rather than what he can because of the necessity of making social adjustments. Hence, in social living there arise rage and distress and fear and anxiety as real as those that grow out of any

primary unconscious conflicts. Adults suffer anxiety as a result of their frustrations, and their sense of frustration increases as a result of continued anxieties.

The program of adult education affords experiences that are personal as well as social and that permit the release of painful emotional tensions that threaten the individual's peace of mind. The diverse opportunities for education are a recognition of the fact that individual differences form the foundation of democratic living. The exposure to different philosophic concepts, the awakening to modern science, the development of external interests help to promote an understanding of economics and literature, religion and trade, history and social relationships. The broader the opportunity for contemplating new thoughts, feelings, and actions, the more intelligent becomes the understanding of the interworkings of majority and minority pressures, the social balances of dominance and submission, and the relative significance of intelligence and emotional reaction.

Mental patterns set by adult education are not simply masses of material to be learned, nor are they merely the expression of propagandizing ideologies. They may enable individuals to realize the value or the lack of value of national ideals. The experienced reaction to the facts, processes, and ideals relating to our culture permits the organization, and often the reorganization, of emotional trends and personal activities. The infinite field of adult education makes possible a continually developing capacity for self-protection and self-realization. This ego advance promotes more intelligent social participation and the acceptance of social change as evidence of a dynamic system of human relationships.

As protective mental hygiene, adult education fosters a greater adaptability in living. Fortunately there is in this field little concern with intelligence quotients, mental age, school progress, or special programs. The emphasis is upon that basic form of education which enables the individual to cultivate within himself that which constitutes his education. It is related to subject matter that is alive and that infuses life because it is self-selected and non-mandatory. The adult is concerned with projects that are related to his

personal ideas, interests, and needs. He himself is the judge of what he likes and what he dislikes. Whether he pursues sociology, literature, economics, psychology, mathematics, music, or painting, he is engaged in the art of living. He is a self-disciplined pupil. He applies himself because he feels the need of contact with the educator. He responds with an awakening of thought and a development of emotional satisfactions. He is making his own adjustments. He is reacting to education as a whole.

The adult is making a voluntary effort to subject himself to some form of training that will facilitate personal adjustment within the environment. He reflects the truth of Burnham's statement: "The common aim of education and mental hygiene is adjustment." Thus adult education is more than a storing up of facts. It recognizes that feelings and desires, attitudes and ideals are not bound to respond to intellectual direction, but none the less are products of some responsive mechanism for adaptation. This is founded upon the effective results of self-discipline through socialized experience.

During the past decade adult education has advanced with great rapidity. It has not grown entirely on the basis of its educational content, but by reason of a recreational factor made necessary by diminished employment and increased leisure time throughout the nation. Unoccupied minds are more dangerous than unoccupied hands, and the expansion of projects for adult education has to a large extent been an expression of rational social psychiatry and an excellent exhibition of sound protective mental hygiene in the interest of the social good.

In ancient Rome the provision of bread and circuses was recognized as having a place in safeguarding the state against class revolt and economic social conflict. Paralleling relief, which provides the bread, adult education has augmented the recreational facilities that constitute the circuses or games which interest and occupy the modern human mind, so that it has less time to dwell upon its own inadequacies and futilities. It offers an infinite variety of courses to meet the needs of all sorts and conditions of men. It provides general and special information, opportunities for discussion and planning, actual shops for the application of technical principles,

and music and art for the development of greater personal accomplishment.

Even this diversity of appeal, which recognizes individual interest and desire, has its protective effect through the resultant ego expansion. Personalities flourish under the influence of broader knowledge, increased self-satisfaction, and heightened skill. Emotional reactions are by no means limited to the class experience, but continually enter into personal adjustments and adaptations within the group. Intensified consciousness of group or class status increases the range of security for the individual. Social solidarity is fostered. A consciousness of the superiority of group bargaining with society is developed as compared with the ineffectiveness of personal effort to beat down the distressing and crushing bars of social neglect, inadequacy, and indifference.

The adult, as opposed to the child, finds a closer relationship between his educational subject matter and his life. He is his own major problem, even though the problem be projected as a complaint against society. Participation at the adult level heightens group consciousness, whether time be spent upon a discussion of Chaucer and Spenser, or upon a local or international situation. The methods of adult education *per se* enhance the growth of personality and may promote a deeper loyalty to the things in which one believes. In so far as adult education becomes a function of government, it fosters insight into the nature and meaning of service by the state to the governed, in contrast with the absorption of the individual by the state.

There is protective mental hygiene in the promotion of true social-mindedness. Discussing human relationships is less effective than living them. Classroom participation in every field should enable the individual to broaden his outlook, although not necessarily his convictions. He grows by exposure to a large variety of personal and group thinking. To the extent to which the adult comes to view minorities as colorful areas in the social fabric, he should be able to increase his open-mindedness and exhibit a welcoming tolerance for the views of others. This lessens the likelihood of the development of paranoid trends, of doubt, suspicion, and false accusation—of fantastic radicalism and culture sabotage.

Even when purporting to set forth only facts, adult education profoundly affects attitudes. It has its influence upon optimism and pessimism, as upon dogmatism and skepticism, in terms of personality organization. As a social institution, however, it affords the protection that develops from experiencing the compromise of opinions, struggling against strong convictions, and finding conflict in the practical expression of one's personal theories while readily granting to others the right to differ completely. There is an interpretative element which links the concept of personal freedom of thought, feeling, and action with that of the exhibition of these freedoms in terms of small and large social groups. This is essential for an understanding of the basic differences in the economic and social points of view attributed to the vested interests in the several geographical centers of our industrial life.

A social consciousness becomes part of the protective value of individual well-being. The doctrine of the brotherhood of man finds support in the values of personal communion with others. The identification of the self with the Deity or with the nation indicates the tremendous supportive control and protective values that once inhered in the relation to a shaman and a chief in tribal organization. Human development has not gone beyond the necessity of finding support for the soul through relationships to others. Personal inadequacy and feelings of inferiority decline through an awareness of larger mental horizons and self-betterment. The distinction between friend and enemy is as inherent in social delusions, hallucinations, and hysterias as in personal mental pathology. If one can speak of an economic depression, one may equally speak of an economic mania and perhaps of a present economic schizophrenia with paranoid trends. Social responsibility for these diffuse emotional states throughout the country cannot be ignored.

If men must find their satisfaction through work and play as related to their lives of love and worship, there is bound to be an interaction in order that personality equilibrium may be preserved. As hours of work decline through technological improvements, more time is available for recreation, even when the general level of employment rises. It is

necessary, therefore, to increase the reorganization of social instrumentalities for balanced living. The extension of parks and playgrounds throughout the country, the development of automobile roads, the establishment of Federal parks, and the spread of adult education are evidences of a definite appreciation of the meaning and effect of social change upon personal satisfaction. The radio and the movies, ball games, sports, pugilism, and wrestling, along with forums, lectures, Town Hall meetings, and organized adult education under municipal, state, and Federal auspices indicate that our present state of social organization requires some new protective leaven that will serve as a vitamin in the social growth of the nation. The protective elements in nutrition do not lie essentially in the solid proteins or in the energizing fats or the satisfying carbohydrates, but rather in the widely varied salts, vitamins, and amino-acids. Lack or insufficiency of the latter group brings about some form of physical disintegration.

Or, to put it differently, the trials and struggles of our present society indicate that we have suffered from a form of erosion which has blown from our top soil of thinking some of the elements essential for continued personal and national growth. The national conservation program is constructively reëstablishing areas of land that could not support family life and that were destructive of social welfare. So adult education is offering new soil upon which man can flourish more adequately, intellectually and emotionally, with the promotion of his physical well-being through a wider growth of his social relationships, and it is a vital conservation program.

The ability to live freely and to grant freedom to others, to accommodate oneself to changing conditions, is part of maturity. Adult education is protectively charged because it is a response to human change, a recognition of the need for a change in the mode of life to meet the changing scheme of living. It guarantees more deliberation because it affords more contentment. It offers escape from carking cares and inner conflicts to external realities, and fends off escape into neurosis. It is not merely negative, but a far-visioned, constructive positive force for the betterment of our national life.

Every civilization has risen and fallen in terms of the emotional states of the people or in terms of forces that have violated the emotional harmonies of certain groups of the community. Every nation functions at an emotional level rather than upon a basis of cold, deliberate, logical reasoning. The hazards of fear, hatred, distrust, and despair are recognized whenever national unity is threatened. People function best in terms of their unities, but these inhere in their feeling toward one another and for one another. The feeling of independence flourishes on a state of interdependence, while security is threatened by a conscious or unconscious dependency.

The great psychological hazard to a nation lies in its emotional conflicts. One may say that feeling is the cement of all social structures, and no nation or government is structurally more sound than this cement which binds its units into a single organization. This is well illustrated by the fact that wherever there is a successful revolution, the primary rush to consolidate the feelings of all the people involves a broad campaign of adult education. The desire is to allay fear, to overcome distrust and calm resentment, and to prevent rebellion. Revolutions, like counter-revolutions, are prevented by awakening emotional responses favorable to the continuance of the *status quo* or to its gradual evolution or piecemeal reconstruction.

The threats of Fascism, totalitarianism, Communism, or even of New Dealism and Hooverism are based upon emotional factors rather than upon the intellectual data that are statistically manipulated to prove the validity of the emotional reaction. The advancement of adult education in this country, which had been proceeding gradually, has recently had a sudden expansion because its value as a protective social force has been increasingly recognized.

Those most profoundly interested in the development of adult education attest its value to the individual, but it is equally significant as a social force in protecting and promoting the well-being of the nation. During the last war, adult education, through pamphlets, journals, minutemen, movies, and other instrumentalities of government, created attitudes which had an emotional core that favored the devel-

opment of thrift, courage, and acceptance of personal sacrifice in order "to make the world safe for Democracy." It was propaganda, but it was adult education. It carried with it by implication the development of feelings for prosecuting the war, and for fortifying the individual against possible suffering as a result of it, in the interest of national success and survival. To-day, in the face of complex propaganda, governmentally supervised adult education occupies a peculiar position to the extent to which it may be exposed to special-interest control over the subject matter presented and discussed. Adult education searches for truth along the road of democratic principles.

The greater the diversity of our current interests, the more varied the opinions expressed in various groups, the more significant is the leveling force of adult education. Members of organizations with similar interests, ideas, and methods work out part of their salvation and develop specific emotional reactions around the core of their group interests. The greater their multiplicity, the greater is the safety of emotional interaction. The essence of democracy is promulgated when adult education promotes a willingness to encourage individual and group differences as rights that can be safeguarded through the unified group that constitutes governmental authority. The safety of the nation is assured by the stabilization of national feelings through the neutralization of group feelings and the emotional releases within the group that lessen emotional tensions for the country as a whole.

Man and nation make emotional progression toward a mature level by their recognition and acceptance of relationships that involve differences of opinion and differences of feeling, differences in method and differences of goal.

In so far as adult education enables the individual to promote his personal adaptation by a better orientation of his personal-social life and by a finer balance of his intelligence and emotions, it is a wholesome, protective form of mental hygiene. It facilitates understanding of the nature and meaning of national culture and appreciation of the value, as well as the danger, of the natural social lag between theory and practice.

Adult education functions to preserve emotional balance.

It protects the individual by enabling him to make a conscious volitional adjustment. It reveals the self in positive and negative relation to social welfare. Mental occupation, with recourse to discussion and interchange of points of view, permits and facilitates an unconscious release from the various and sundry conflicts arising from past personal training and current experience.

Thus adult education brings about a twofold interpretation of self on the basis of an ego and an *alter ego*. There are those whose egos are constricted and whose egocentric views of life lead them to constant conflict with the world about them. There are others whose egoism has expanded into an idealism that transcends practicality. Adult education makes it possible for both to work coöperatively in the interest of their not wholly dissimilar goals and even to compete in methods that will bring about a more practical realization of their common belief in the betterment of the nation. After all, educational competition is stimulated through growth of the ego, and social coöperation is advanced through a better understanding of the meaning of competition. This education is not merely a leveler, it is a leverage that at least raises the level of mediocrity. There is no aristocracy of brains in adult education, but rather a democracy of effort. To paraphrase Ingersoll, it polishes pebbles without dimming diamonds.

It is fair to say that adult education has been serving as a definite factor in the moral well-being of our citizens. It offers a better understanding of and a deeper feeling for what they regard as fundamental in a democracy. The recreational facilities inherent in it have been a vital element in promoting national morale. And a heightened morale is a lever for social morality or the orderly development of patterns of living. The roots of morale draw sustenance from the feeling of security. They thrive on an appreciation of the meaning of citizenship, with all its rights and obligations. Morale grows in intensity as personal expansion finds greater richness in the institutions that make the education possible. Spiritual gains and spiritual strength are protective by-products that evoke further emotional satisfaction. A sustained morale is exemplary mental hygiene.

Both education and government are flexible and can, there-

fore, find media for meeting public needs and demands. The spirit of an age and a time is reflected in varying educational systems, but each government endeavors to translate its own spirit into and through its educational activity. The adult-education program of this country may make its appeal to the intelligence, but its protective value arises from its stabilization of feelings, its harmonization of attitudes, and its activation of rational adaptation to change.

An individualistic doctrine of "Mind your own business" implies the necessity of having some business to mind and some mind to apply to it. Adult education is part of the business of the social mind because it protects the private mind which, with unified purpose, protects the social mind. Adult education is part of the business of government, and the business of government should be part of the business of every citizen. Hence it is clear that adult education is a phase of mental hygiene and that mental hygiene forms an integral part of adult education and public health. The individual adult may more certainly attain his maximum of efficiency, with the maximum of happiness and the minimum of friction, when he enjoys the protective value of a continuing education that enables adults as individuals to pursue together those ideals which are set forth in the democratic Bill of Rights.

PREMARITAL COUNSELING IN THE PHILADELPHIA MARRIAGE COUNSEL *

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THE stated purpose of the Marriage Counsel of Philadelphia is "to help young married couples and those contemplating marriage to a better understanding of what companionship in married life involves, and thus to help them avoid some of the causes of marital difficulties." There are two main divisions of the work, as described in an earlier paper in this journal [1]—individual consultation and educational services through groups. The latter include participation in the teaching of college and high-school courses and talks to clubs and to church, professional, and other groups,[2] giving many hundreds of young people an opportunity to obtain information, to secure relief from anxiety, and to gain reassurance. The individual counseling attempts to offer to the client through a personal interview a positive and dynamic approach to his problems which may result in a better understanding of self, greater reassurance, and an enhanced capacity to live adequately.

In this study we shall consider only the individual consultation service with clients who come before they are married. We believe that the premarital work offers a unique illustration of the whole philosophy of marriage counseling.

Clinical Material.—Two hundred cases from the Marriage

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1 "An Analysis of One Hundred Consecutive Cases in the Marriage Counsel of Philadelphia," by Emily H. Mudd. MENTAL HYGIENE, Vol. 21, pp. 198–217, April, 1937.

2 See "A Coöperative Project in Marriage Counseling," by Emily H. Mudd and Bernice Lundien. *Human Fertility* (formerly *Journal of Contraception*), Vol. 5, pp. 121–25, August, 1940.

Counsel records form the basis of the study. We may define these premarital cases as those who, at the time of their contact with Marriage Counsel, either were engaged or were definitely considering marriage with a particular individual. These clients were seen for one or more confidential interviews, in which they presented their problems for discussion without any standardized procedure or investigation on the part of the counselor.[1]

The clients in this group were young people above the average in education and intelligence, with moderate incomes, coming for the most part from American homes in and around Philadelphia. One hundred and fifty-two of them were women, and 48 men. In 50, or 25 per cent, of these cases, the young person either came with the fiancé or brought the fiancé later for a separate interview. In the other 150 cases, only one of the young couple was seen.

The age grouping of the 200 cases was as follows:

Age group	*Number of cases*
18–20	13
21–25	114
26–30	42
31–40	28
41–50	2
Not given	1
	200

As to religion, the cases fell into the following groups:

Religion	*Number of cases*
Protestants	133
Roman Catholics	22
Jews	40
No affiliation	2
Not given	3
	200

Comparing the data on this premarital group with those on two hundred consecutive cases from the general file of the Counsel, we find that the proportion of men is slightly higher in the premarital group than in the general cases. The majority of the premarital clients were between twenty and thirty years of age, while the general cases show a wider age range. The religious distribution is approximately the same.

[1] See "Is Marriage Counseling a Profession?" by Robert Foster. *Parent Education*, Vol. 3, pp. 47–8, April, 1937.

The educational background of the premarital group indicates that they do not represent a typical cross-section of the population:

Education	*Number of cases*
Grammar school	6
High school	78
High school plus vocational or business training	52
College	40
College plus graduate or professional training	19
Not given	5
	200

These premarital cases have an even higher educational background than that presented by the two hundred consecutive Marriage Counsel clients, whose educational level was well above that of the population as a whole in the United States. All but 3 per cent of this premarital group had had at least a high-school education, and nearly 30 per cent had been to college.[1] These facts are significant chiefly because they seem to indicate that at present either contact with informed sources or more than average intelligence and initiative is required to lead young people to seek the help of such a service.

It is interesting to note the sources from which these young people were referred to the Marriage Counsel:

Source		*Number of cases*
Private individuals		59
Former clients		25
Professional sources:		
Physicians	21	
Educators	3	
Ministers	15	
Social workers (as individuals)	11	
		50
Pennsylvania Birth Control Federation or Maternal Health Centers		20
Educational work by counsel:		
Courses and talks	29	
Articles	17	
		46
		200

[1] See "The College and the Preparation for Marriage and Family Relationships," by J. Stewart Burgess. *Living*, Vol. 1, pp. 39–43, Spring and Summer, 1939.

A word of explanation is needed as to this tabulation of sources: "Private individuals" as a source means that the client heard of the Counsel through a friend, or learned of it through personal professional contacts, through reading, or perhaps merely through seeing the sign on the door. The small number of clients referred by "educators" must be considered in connection with the educational work of the Counsel. Many talks or courses are given by the counselors in educational institutions, and in this way the institution acts as the medium through which not only are specific clients brought in for personal counseling, but hundreds of other young people are given general instruction for marriage and family life. In many instances the course eliminates the necessity for an individual interview because the students' questions are answered in the group discussion.[1]

There are three outstanding differences between the sources of the premarital cases and the two hundred general cases: (1) three times as many premarital clients were referred by former clients; (2) more than twice as many of the premarital cases came as a result of educational work by the Counsel (nearly a fourth of the premarital cases came in this way); and (3) no premarital cases came from social agencies, although a few social workers as individuals referred their "friends." This lack of cases from social agencies is striking, and may be due to one of two causes—either premarital problems do not come within the scope of social agencies, or they may be handled by the agencies within their agency function. Many family-service agencies to-day undertake to help with problems of emotional adjustment between parents and children, and as such may be contributing to the stability of the marriages in the next generation, but few of them undertake the specific task of premarital interviewing. It would seem that the specialized service of premarital counseling offers to the economically independent, as well as to those less fortunate, something that they can use as they do other specialized professional services.[2]

[1] See *Clinical Material From a Marriage Counsel—Its Relationship to College Courses on Marriage and the Family*, by Emily H. Mudd. A paper presented at the Tenth Annual Meeting of the Eastern Sociological Society, Asbury Park, April 22, 1939. Available at offices of Marriage Counsel, Philadelphia.

[2] See "The Physician as Counselor in Marital Adjustment," by Ruth Brickner. *The Cyclopedia of Medicine, Surgery, and Specialties.* Second edition. Philadelphia: F. A. Davis Company, 1940. Vol. 12.

The Pennsylvania Birth Control Federation and their maternal health centers are listed separately, rather than as social agencies, because of the specialized nature of their work. Their policy does not allow them to accept unmarried clients as clinic patients, but does allow them to refer such persons to individual physicians. Both unmarried and married persons who come to their offices to discuss adjustment in marriage are referred to Marriage Counsel.[1] In contrast to the policy in Pennsylvania, which is followed at present by most other birth-control clinics in the United States, the Cleveland Maternal Health Center has accepted clients for premarital contraceptive instruction and considers this a most important part of their service.[2]

Perhaps it is an index of the value of the organization that the sources of more than one-third of all the cases that come to the Marriage Counsel, both of the premarital and of the general group, are private individuals. Here is a small, inconspicuous office, to which people may come or send their friends to discuss certain of the most intimate phases of their lives. The clients are interviewed in confidence, and since the service is on a fee basis, there is no sense of obligation on the part of the client to leave or to return, except at his own will. The increasing number of persons who are sent by former clients is the most gratifying response we have received.

The average fee paid by the two hundred premarital clients was $1.22. This is slightly higher than in the group of two hundred consecutive cases, in which the average was $1.08. In a number of instances the fee was waived entirely; in others it varied from twenty-five cents to ten dollars. All clients are told that from three to five dollars is the customary fee. Although client's fees are an almost negligible source of support, they are felt to be of importance in aiding the client to define his relationship to the service, to retain his independence and self-respect, and to feel free to sever his connection when he is ready.

1 See "The Relation of Marriage Counsel to the Maternal Health Center," by Emily H. Mudd. *Birth Control Review*, Vol. 4, pp. 4–6, December, 1936.

2 See *Premarital and Preconceptional Care*, by Gladys Gaylord. A paper presented before the American Congress on Obstetrics and Gynecology, Cleveland, September 11, 1939.

The relationship between the date of the premarital interview and that of marriage is important:

Date of interview before marriage	*Number of cases* *
1 week or less	55
1 week to 1 month	53
2 months to 6 months	39
6 months to 1 year	5
Indefinite	31
	183

* Seventeen cases are not included as they were not definitely engaged at the time of the interview.

More than one-quarter of the clients came to Marriage Counsel one week or less before their marriage. This was a disadvantage, as the shortness of the time made it difficult for the client to arrange for the medical examination which almost all of them wished after their interview with the counselor. The time factor also has a bearing upon the function of the counselor, who has to be careful not to precipitate problems in the client's mind that cannot be properly thought through before the marriage, and that may be upsetting to the client if left unsolved. Undoubtedly the new state laws requiring some medical examination prior to marriage will help to obviate this difficulty, as inquiries may be brought earlier to those who are called upon to do premarital counseling.[1]

Questions Presented by Clients.—We have considered the premarital clients in three categories, as has been done in other studies from the Philadelphia Marriage Counsel: (1) the "normal" young people who come in with rather typical questions about sex adjustment, contraception, and the psychological aspects of relationships in marriage; (2) young people who come in with a specific problem; and (3) those with personality difficulties, which we call the "generally upset" group. The distribution of the 200 cases in these three categories was as follows:

Type of case	*Number of cases* *
"Normal"	151
Presenting specific situation	27
"Generally upset"	30
	208

* Eight cases fell into more than one group.

[1] See editorial, "Premarital Examination Laws in the United States," in *Human Fertility*, Vol. 5, pp. 91–2, June, 1940.

We see that about 75 per cent of the premarital cases fall into the "normal" group. Of these about one-quarter were primarily concerned with obtaining reliable contraceptive information. The others were eager for this information, but were equally anxious for other facts and for reassurance that would allay their uncertainty as they faced marriage.

Clients of this type usually have little hesitancy about asking for contraceptive information, and although it is sometimes difficult for them clearly to verbalize their other questions at the beginning of an interview, these often arise naturally out of a preliminary discussion of anatomical or physiological facts. As we have seen above, most of the young people who come have intelligence and initiative and seem to have done a good deal of thinking about marriage beforehand. Frequently one hears the statement, "My fiancé and I have talked a lot about these things already." With a degree of objectivity already achieved, there is often little embarrassment, and definite questions are already in the client's mind. Then, too, the very fact that these are classed as "normal premarital" clients means that they are not floundering in the emotional turmoil of early adolescence, nor are they beset with pathological fears or worries. There is a natural, straightforward atmosphere in the majority of these interviews, the client presenting his questions with little reserve, and the counselor's respect for the client's independence and initiative, coupled with lack of inquisitiveness into his life history or possible "complexes," perhaps doing more to reassure the young person than any of the factual material presented.

Sometimes, during the course of an interview, the client mentions a fact that may seem to the counselor of great potential significance in the forthcoming marriage, such as that the fiancé is still under supervision because of a "nervous breakdown" two years before; that the fiancé is "just like his family" and from a very different background from that of the client; or that the girl has lost fifteen pounds and acts tired all the time. When such facts are not brought up by the client as questions for discussion, what is the counselor's responsibility? One or two careful questions will usually indicate whether the client has obtained medical advice,

where health is involved (if he has not, reference to the proper source is obviously indicated) or whether he has or has not accepted a situation with adequate perspective, where family or personality matters are involved. The counselor may be seeing the client for a single interview one week before his marriage, and in the majority of cases does not feel justified in enlarging upon what may seem to be ominous possibilities. A second visit before marriage may be suggested or, if this is impossible, the way may be left open for the client to return after marriage, the counselor remarking that often problems arise in this period and that Marriage Counsel welcomes later visits from those who have been seen before marriage.

Situations in which serious complications are obvious are taken up in detail in the discussion of "generally upset" clients.

About two-thirds of these "normal" clients were referred as an additional aid to a physician for an examination and for more detailed contraceptive instruction.[1] (No physical examinations are made in the Marriage Counsel.)

Books or pamphlets are furnished to supplement the interview when the clients so desire, as was the case with about two-thirds of this "normal" group. Before suggesting reading material, it is the counselor's responsibility to decide how far the individual has already developed. Books are selected as much for the attitudes that they help to foster as for their factual information.[2] Some of the clients preferred not to read at all before marriage. For the most part, this "normal" group were able to accept facts and to enter marriage with many fears dispelled. Examples of books that might be used are those by Butterfield, Groves, Stone, Clark, and Himes.[3]

[1] See "The Premarital Interview; An Interpretation of Professional Attitudes and Procedures," by Emily H. Mudd. *The Cyclopedia of Medicine, Surgery, and Specialties.* Second edition. Philadelphia: F. A. Davis Company, 1940. Vol. 12, pp. 812–20.

[2] See "Use and Misuse of Books in Counseling," by Emily H. Mudd and Jean L. Whitehill. *Parent Education,* Vol. 4, pp. 139–44, February, 1938.

[3] Books by these authors that might be recommended are *Marriage and Sexual Harmony,* by Oliver Butterfield (New York: Emerson Books, 1934); *Preparation for Marriage,* by Ernest R. Groves (New York: Greenberg, 1936); *Marriage Manual,* by Hannah and Abraham Stone (New York: Simon and Schuster, 1935);

A few examples from this group of cases will illustrate the constructive work that can be done:

An undergraduate college girl who was engaged came seeking instruction that she could not find in the curriculum on matters of sex hygiene and premarital problems. During her interviews with the counselor, she was given information on the physiology and psychology of sex and reproduction, borrowed some books to read, and was subsequently referred to a physician for examination and contraceptive instruction. Although she was a privileged girl, of intelligence and wide background, she was tremendously relieved to find an appropriate source of help at that particular stage of her life.

Another girl of very simple background was facing marriage with a good deal of trepidation. She was encouraged in her plans to make a home separately from her husband's family, as she talked over the question of her fiancé's dependence upon his mother. Her fear of pregnancy in the face of economic insecurity was relieved by adequate contraceptive information and it was learned a year later that the marriage was so far a happy one.

An encouraging situation was presented by a couple who asked to talk to the counselor together and raised questions freely about marriage relationships. They shared the responsibility of securing adequate guidance for themselves and later sent two other premarital clients for interviews.

In other cases, clients seen before marriage have returned to discuss problems that have arisen after marriage. A girl who had attended one of the courses given by Marriage Counsel at the Y.W.C.A. came before her marriage for contraceptive information, and then returned two months after marriage with questions as to sexual adjustment, on which she was given considerable help.

The specific problems brought in by the second group of our premarital cases were of many kinds, but almost all were of such a nature that it would have been difficult for the young persons to discuss them with their own families.

Emotional Adjustment in Marriage, by LeMon Clark (St. Louis: C. V. Mosby Company, 1937); and *Your Marriage*, by Norman E. Hines (Appendix B of *Functioning Marriage and Family Counseling Services in the United States, April 1, 1940.* New York: Farrar and Rinehart, 1940).

Here again, however, we find little hesitancy in "getting to the point" in the counseling interview. Once they have decided to bring their problems for discussion and have actually dealt with the practical difficulties of making an appointment and getting to a strange place, the greatest obstacle to frank and free use of the service has already been overcome. Relief rather than constraint usually characterizes the presentation of the story. Obviously, such freedom is possible only when the counselor's attitude is felt to be one of sympathy and understanding which accepts the client's situation for what it is and offers him, not moral approval or disapproval, but help in determining what for him and for the other persons involved is the most constructive solution of his problem.

There were several clients who were worried over the question of the inheritance of mental disease; others were afraid of venereal disease; and a few men came because their fiancées had become pregnant. There were five blind clients who wanted to discuss the question whether they should have children, and if not, whether sterilization was indicated.

In many of these cases the counselor not only discussed the problem in detail with the client, but referred them to experts for further help. For example, a young woman who was worried over her fiancé's recent nervous breakdown was able to talk this through with the counselor. She was assisted in securing the opinion of a psychiatrist as to the prognosis and the relationship of the fiancé's condition to any children that the couple might have. Another case in which the woman asked for help in obtaining a medical examination for herself and her fiancé resulted in postponement of the marriage until the man had been treated for venereal disease.

One young woman came because she was worried over the relationship of her fiancé to his mother. She sensed that there was something in that relationship that might be a stumblingblock in her marriage and she went away understanding the problem more clearly because she had talked it out with some one.

It took courage and intelligence for these young people to seek guidance, and they were deeply grateful at having found an appropriate source of help. Even though these clients

with specific questions are often seen only once or twice and then are sometimes referred elsewhere for additional help, it is felt that the service that is rendered them by the Counsel is essential to them and may have far-reaching consequences.

The third category of "generally upset" cases comprised 15 per cent of the premarital clients. Half of them were from the group who were not yet definitely engaged at the time of their first visit to the Counsel. A number of these had serious conflicts over the separation from their own families that was required by marriage. Others in this "generally upset" group were doubtful about the advisability of their marrying, while some had an unusual amount of fear as they approached the date of their wedding. These individuals revealed deep-rooted personality problems growing out of childhood experiences. It is not the function of Marriage Counsel to serve as a psychiatric clinc, nor is it equipped to do so,[1] but some of these cases are not ready to seek psychiatric treatment and the counselor is able only to offer what help he or she can on the problems about which the client comes to Marriage Counsel.

Contact with these "upset" clients sometimes results in the postponement of the marriage, the breaking off of the engagement, or occasionally in a series of visits over a period of time during which the client attempts to work out a personality problem with the help of the counselor.

The primary object of such a service as ours is to meet the need of the client as he presents it in terms of his immediate problem. Although the counselor believes, and may gradually help the client to realize, that his marriage adjustment reflects his total personality, the focus of discussion may be one specific aspect of the marriage or family life. It has been our experience that a clarification of the environmental and personality situation in the client's mind, and a realization of his own potentialities for dealing with his situation, may in themselves initiate more constructive attitudes leading toward growth and change.

[1] See "One Preventive Approach to Marital Maladjustments," by Emily H. Mudd. A paper presented at the Ninety-fifth Annual Meeting of the American Psychiatric Association, Chicago, May 4, 1939, and summarized in a round-table discussion, "Unsuccessful Sex Adjustment in Marriage," in the *Journal of Contraception*, Vol. 4, December, 1939. p. 233.

Miss A, a woman just over thirty years old, came to the Marriage Counsel stating that she felt there must be something wrong with her because of her apparent inability to develop social contacts with men. An only child, brought up by a strict family who tolerated no freedom or frivolity on her part, she had finally broken away from home and was holding an excellent business position. She admitted that she was a perfectionist in her attitude toward other people, and said that she had failed in several attempts to become "one of the crowd." "I am just left looking on at the fun." The counselor discussed with Miss A the need for giving as well as getting in friendship. It was suggested that she try to evaluate the attractive qualities of the girls whom she admired most. Miss A borrowed several books from the Marriage Counsel library and that that she would like to come in again later.

In less than a month, Miss A was back, saying, "Well, I have tried to change my way of going about things and it is just unbelievable what has happened." She had been to a beauty expert, had attended a course in public speaking, and "in addition I have tried to be much more friendly, and the response that I have gotten is much more than I ever expected. I value my friendships now. . . . I seem to have gotten alive for the first time." Several men had noticed her and she had started going out steadily with one man whom she was beginning to think of as a possible marriage partner. Miss A continued to use this service occasionally as she worked out her problems.

Such dramatic changes do not often occur, of course, but this case is a striking illustration of the release of potential capacities for richer human relationships. If Miss A marries now, it will be with a real zest for life and a confidence in herself that will insure her greater happiness than she could ever have had with her former restrained, hypercritical attitude.

In another instance a woman who came with doubts as to the advisability of her marrying finally gave up the idea of the marriage and was able to adjust herself successfully to this new situation. In other cases such as the following, long-standing conflicts or inflexible personality traits prevent the individual from achieving any fundamental change through contact with such a service as Marriage Counsel:

Mrs. B had been an enthusiastic member of a class in preparation for marriage, and followed this by going for a premarital examination to a physician recommended by Marriage Counsel. However, during the four years after her marriage, she did not come to Marriage Counsel. She later reported that she and her husband had grown apart and finally separated. Mr. B was of a different nationality and remained closely bound to his own family and tradition. They had been forced by economic pressure to live with his people at first, and he later refused to establish a separate home, even when they were able to do so. Apparently neither of them was able to compromise or sufficiently flexible

to adjust to the needs of the other person, nor were they sufficiently unhappy without each other to make any further effort to stay together. Mrs. B finally said, "I have lost all the feeling I ever had for him."

Use Made of Counsel by Clients.—The use that was made of the Counsel by the clients in this premarital group may be summarized briefly in the following figures:

Number of interviews	*Number of cases*
1	163
2	24
3	4
4	5
6	1
7	1
8	1
10	1
	200

Cases referred after Marriage Counsel interview to physicians for premarital examination		108
Reports received from physician that client went for premarital examination		80
Cases referred after Marriage Counsel interview for other medical advice or for legal, financial, or other services		31
Known to have used these services	19	
Known not to have used these services	7	
Not known whether service was used	5	
Cases referred to psychiatrist		2
Clients who used books or pamphlets		124

These figures are consistent with the policy that has been maintained since the beginning of Marriage Counsel of limiting the greater part of its work to short contacts in a fairly clearly defined area with young, so-called normal individuals. There has been increasing emphasis in the last few years upon the significance of the single interview as an important function of case-work.[1] Clients who are seen only once offer a challenge to the counselor to make of that interview something that is clear, constructive, and stimulating, so that the individual may be better able to meet the problem or situation that prompted him to seek help.

[1] See *The Short Contact in Social Case Work*, by Robert S. Wilson. New York: National Association for Travelers Aid and Transient Service, 1937.

We have assumed that the major benefit from such a service as ours is derived from those unspoken, but deeply felt reactions which may occur at the meeting of two individuals. A young person who makes up his or her mind to seek outside help from a marriage counsel is taking a step as yet not routinely customary for all of his group. If, after arriving at this resolution, he continues through the necessary formalities of telephoning ahead for an appointment, finding a strange office, introducing himself to the secretary, and meeting the counselor, he has proved to himself as well as to the counselor that he really wants to do something about his situation. This is an emotional experience, which brings confidence to the client, and an intensified participation in the actual interview, and which constitutes the most important step in his ability to make use of the service.

The client can then feel, from the appearance, the tone of voice, and the expression of the counselor, his or her attitudes and philosophy of living, in particular as it relates to marriage.[1] Here is another individual who has lived through the same experience that the client himself is about to face, and who quite naturally, merely by being himself or herself, gives reassurance, understanding, sympathy, and good cheer. This unspoken, but deeply felt, interchange may be responsible in great measure for the finding, borne out by seven years of work, that so much seems so often to happen in only one or two interviews.

It is difficult to define methods or results in such a highly individualized approach to the problems of marriage. We believe, however, that a certain degree of growth can be effected in the early years of marriage or before marriage through a counseling relationship, and that such change is expressed by the client's crystallization of a plan of action or by some change in attitude. Such change, in our experience, can occur only when the client himself has a sincere desire for help. The attitude of mind of those few who come *only* because they have been urged to do so by some well-meaning

[1] In the Marriage Counsel of Philadelphia all of the counselors are trained in some professional field, in addition to having had the living experience of marriage and parenthood.

friend or professional person renders an interview of little value to them. Even though the counselor may be cognizant of many problems, discussion of them is usually academic and sterile, without a sense of actual participation on the client's part.

No formalized personality studies are made of our clients or of their case records, but each client situation is evaluated not only in terms of the nature of the problem and the source from which the case was referred, but in relation to the help that was given the client, and what the client was able to do for himself after the interview. Was he able to understand and to make use of the content of the interview? And if he was not able to make use of it, was the technique of the interview at fault or was the client's personality too rigid and his problem too deep-seated to be influenced by such a discussion? In considering any individual client, it may be helpful to remember Dr. Plant's definition of the three aspects of the personality:[1] (1) the inherent, basic, permanent structural elements; (2) the mental attitudes or habits, which in general are found rather early in life and which have a high degree of resistance to change; and (3) "the rest of the personality"—those day-by-day changes that go through rather wide swings, even though they are reined in considerably by the basic elements and the early attitudes. In a clinical service, in which the majority of cases are seen on a short-term basis, changes for the most part appear to be in this third category, but the eventual outcome sometimes shows that the more basic attitudes have been altered as well.

Among the questions that face a counseling service are several related to follow-up contacts. Should any attempt be made to bring the client back for further interviews? So far, except with a limited group of the normal premarital clients, no attempt has been made to follow up the cases beyond the reports from specialists and voluntary reports or further visits from the clients themselves.

Our later contacts with 200 premarital cases were as follows:

[1] See *Personality and the Cultural Pattern*, by James S. Plant. New York: The Commonwealth Fund, 1937.

Nature of contact		*Number of cases*
Return visits from clients:		
Client seemed well adjusted	22	
Client returned with difficulties	15	
		37*
Reports received by Marriage Counsel from clients or their friends:		
Client seemed well adjusted	43	
Client with difficulties	2	
		45
No replies to follow-up letters†		36
No follow-up beyond report from specialist to whom client was referred		40
No later contact with client		42
		200

* A total of 74 return visits were made by these 37 clients.

† The figures on follow-up letters apply only to the "normal" cases. As an experimental procedure, uniform letters were sent out to about one-third of this group three months after the initial interview.

Sometimes at the end of an initial interview the counselor may have a strong belief that it would be to the client's advantage to return for further consideration of his problem, and may suggest such further contact to the client. However, as we have said, experience in this and allied clinical services strongly indicates that a counseling relationship is constructive only in so far as the client is ready for the program, and at least partially able to make and to carry out his own plan of action. With some clients this is an almost immediate process; with others it is impossible at first and ability for it develops only little by little during a counseling relationship that continues over a period of time.

We believe that the contribution of such short-service interviewing depends upon the kind of client, the type of situation presented, the training and attitude of the counselor, and the philosophy of the organization. Where there is freedom from the need to justify any particular theoretical hypothesis, and from traditional organizational procedure, experimental efforts in this field offer a unique opportunity. The Marriage Counsel of Philadelphia has, we believe, been able to provide such a setting, and we offer our interpretation of results with

open-mindedness and the realization that of necessity it is incomplete.

The Function of Premarital Counseling.—An analysis of the premarital cases should help us to define more clearly the function of this aspect of a counseling service. We find that the counselor acts as an agent in one of two broad processes: (1) an educational process and (2) a therapeutic process. No sharp line can be drawn between the two functions, which may both be required in the same case, but separate consideration of them clarifies discussion of the rôle of the counselor.[1]

1. The majority of the premarital clients are normal young people who seek guidance such as any one logically requires before embarking upon a new field of activity. Even though they may have had an adequate formal education and satisfactory social relationships, the engagement period means that they are faced with new adjustments, and naturally have questions that could not have been answered earlier. The fact that they bring their problems to a marriage counsel is an encouraging indication of readiness to attempt to face reality.

The question has been raised as to how far one can help to prepare another person for an experience that he has not had. In a recent address before the Marriage Counsel of Philadelphia, Dr. James S. Plant [2] discussed this question as a stimulating challenge to marriage-counseling work. From the clinical material we have studied here, a partial answer seems to emerge. Dr. Plant says: "If you answer this question—as to whether, in the formal sense, you can educate for the future—in the field of marriage counseling, you are in reality serving a much wider field. Over very large areas of human experience we are asking precisely this same question: How far can you educate a person in an experience before he is ready for, or engages in, that experience?" Since all but a small fraction of the unmarried persons who have come to the Counsel are either engaged or considering marriage with a definite person, are they not "ready," both intellectually and

[1] See "Function and Process in Psychiatric Social Work." *News Letter*, American Association of Psychiatric Social Workers, Vol. 9, pp. 1–32, June, 1939.

[2] See "Present Problems in Marriage Counseling," by James S. Plant. MENTAL HYGIENE, Vol. 23, pp. 353–62, July, 1939.

emotionally, for a growth process to begin,[1] even though they cannot achieve their new equilibrium until after marriage? In other words, are they not eligible for the best guidance that science and philosophy have to offer, however inadequate that guidance may be? The educational opportunity is enhanced by the strong emotional drives that are impelling them toward marriage, which make them eager to grasp and to use help.

Ideally, perhaps, one might wish that this help could come always from parents, teachers, ministers, or physicians, whose values have already been absorbed by these young couples, so that the personal influence of the relationship would intensify the learning process. Actually many of the younger generation are too often unable to talk freely with the older people whom they know personally, and these young people find themselves less restrained in their questioning in an impersonal setting, such as the Counsel offers. This implies that the educational process involves far more than factual information, and that the attitude of the counselor is of fundamental importance. We like to think of counseling as defined by Gilbert Wrenn: "a personal and dynamic relationship between two people who approach a mutually defined problem with mutual consideration for each other, to the end that the younger or less mature or more troubled of the two is aided to a self-determined resolution of his problem."[2]

There has been justifiable criticism of the many books that concentrate on sex technique, especially when they imply that these techniques are formulæ for happiness in marriage. The counselor's rôle as an educator is significant if the client can be helped to think of sex as one form of expression of his personality, and to realize that the personality as a whole is going to be called upon to meet the demands of marriage. If the premarital discussion can increase the client's confidence in his ability to meet new situations, he may approach the unknown areas ahead of him with a better perspective. His request for factual information may be the point around which he crystallizes his realization of his capacity for growth.

[1] See "The Dilemma of Growth," by Frederick H. Allen. *Archieves of Neurology and Psychiatry*, Vol. 37, pp. 859–67, April, 1937.

[2] From "Counseling with Students," by Gilbert Wrenn. Chapter 4, Part I of *The Thirty-seventh Year Book of the National Society for the Study of Education*. Bloomington, Illinois: Public School Publishing Company, 1938.

Certainly no pedagogical sex instruction should be imposed from without that would hamper the development of a spontaneous and unique relationship between two persons as they embark upon marriage.

2. The second aspect of the counselor's task we may call therapeutic, if we recognize that a preventive approach to problems of family relationships must deal with the attitudes and problems that the individual brings with him to the interview, as well as with the new adjustments of marriage. As we have just seen, one of the primary functions of premarital counseling is to help the client understand that his marriage adjustment will reflect his total personality. So in every case —whether "normal," specific, or "generally upset"—the counselor should be ready to look below the surface for the attitudes that will influence the future of this marriage far more than knowledge or lack of knowledge of any specific set of facts.

For example, a girl comes in with the stated purpose of securing contraceptive information, but starts the interview by saying, "I have so many friends who are unhappy, and I want to know how to avoid trouble," or, "My family don't want me to leave home, and they say my fiancé is hard to get along with." To focus the discussion on anything but the basic questions of her attitudes and her potential capacity to build a successful relationship would be to fail to carry out the most important task of counseling.

There are three aspects of the therapeutic process: (1) recognition of difficulties; (2) steering the client to a source of help if that properly lies within the sphere of another agency or profession; and (3) providing treatment within the counseling relationship.

The recognition of difficulties by the counselor is essential to the proper conduct of the interview. Their recognition by the client is of even more significance and is often the chief benefit derived from the short-contact case-work that is typical of premarital interviewing. The client may see himself objectively in relation to his fiancée for the first time, and even though he may not be able to use his new insight completely, it may give him a tool for creating a constructive relationship. In some instances understanding of self leads to a

change of plan even before marriage. Often the young person or couple is seen only once, for an hour, and if too much is brought up, it may be just as destructive as if the counselor did not sense any problems at all. As in medicine, judgment as to what the patient is ready to stand is fundamental to good treatment.

By the steering function, we do not mean the referring of clients for premarital physical examination, which is really a part of the educational process, but to those cases in which the recognition of difficulties leads to the use of community resources—such as social agencies which provide channels for self-expression or relief from family burdens—or to the use of experts for consultation on specific questions, medical, legal, or psychiatric.

The counselor undertakes treatment in those cases in which the degree of help needed lies within the scope of Marriage Counsel service and in which the client probably would not be ready or willing to apply to other resources for such help. We have seen that in relatively few cases is an extensive treatment relationship developed, and it is a question as to how intensive the treatment should be in such an agency as Marriage Counsel. At the time of life when most of the premarital clients come to the Marriage Counsel, their reactions are apt to be so intense that too radical an analysis is out of order unless there is real doubt as to the advisability of the marriage's taking place at all. A clarification of the environmental and personality situation in the client's mind and the bringing about of a realization of his own potentialities for dealing with his situation would seem to be a reasonable goal.

The counselor who undertakes to help with the emotional problems of those clients who come before marriage is obviously assuming tremendous responsibility.[1] It is also a great responsibility to attempt to make a positive, constructive contribution to these young people that will constitute a truly educational experience. Marriage counseling would be open to just criticism, however, if it provided only factual information and instruction in sex technique. Reading material and

[1] See "The Marriage Situation in Relation to General Medicine," by Edward Weiss. *The Cyclopedia of Medicine, Surgery, and Specialties.* Second edition. Philadelphia: F. A. Davis Company, 1940. Vol. 12, pp. 805–12.

medical examinations would be sufficient to cover these needs. Reassurance and a sense of values should be the outstanding contribution of premarital counseling.

CONCLUSION

It is obvious that counseling interviews before marriage can in no sense guarantee successful adjustments after marriage. Such interviews, however, may offer to an engaged couple or to an individual attitudes and information of constructive value on the spiritual, physical, and emotional aspects of human relationships. They may serve as a point of departure for the relief of certain fears and worries based on lack of reliable information or on other more obscure psychological factors. They may at times prevent marriage from being undertaken at all. The opportunity for such contacts as are depicted in the premarital interview comes at a period in life when reactions of all kinds are intensified. When the applicant does not present a picture of extreme mental or physical pathology and is able to utilize the stimulus of this period constructively, these interviews may be one of the focusing points around which growth and development are initiated.[1] Increasing evidence from follow-up cases seems to indicate that help made available through the channels discussed in this article can be a valuable aid to marital adjustment.[2] Apparently the clients of such a service as Marriage Counsel get what they are not able to find so readily elsewhere—information, understanding, and freedom to talk and to ask questions.

The need for premarital counseling may be an expression of the cultural condition of our times.[3] Preparing young people for marriage is not a new procedure. It has been done in some way in every era of civilization. In primitive society the adolescent was inducted into marriage after a series of taboos and rituals. Where marriage has been regarded primarily as a social and economic contract, it has

[1] See *Dynamics of Therapy in a Controlled Relationship*, by Jessie Taft. New York: The Macmillan Company, 1933.

[2] See "Youth and Marriage," by Emily H. Mudd. *Annals of the American Academy of Political and Social Science*, Vol. 194, pp. 111–18, November, 1937.

[3] See "The Family as Cultural Agent," by Lawrence K. Frank. *Living*, Vol. 2, pp. 16–19, February, 1940.

been approached as a business agreement between two families, with little emphasis on the individuals involved in it. In our present highly individualized American life, no such prearranged customs are imposed upon young people. They are left to work out for themselves a plan for marriage that is largely based on a romantic ideal.

Perhaps this pioneering in social freedom is but a new stage in the evolution of a culture that has already come through struggles for religious and political freedom. In this stage it is up to the individual to seek out the help that he needs.[1] Courage and initiative are necessary to enable young people to ask for premarital advice. The insistent demand by students in schools and colleges for courses on marriage and family life will lead to greater knowledge and more constructive group thinking about these subjects. The changing status of state marriage requirements also offers a new resource for those who are looking for assistance in planning marriage. While these developments in education and health will themselves meet the needs of many young people, they may stimulate in others a desire for individual conferences in such a setting as a marriage counsel offers.[2] It is essential, therefore, constantly to study and to interpret the function of premarital counseling, and to relate this function to the changing needs of the community. A unique opportunity is presented in this work to coöperate with many other efforts that are being made to stabilize and enrich family life,[3] and it should serve as a point of departure for constructive future developments.

[1] See "Occupational Status and Marriage Selection," by Thomas C. Hunt. *American Sociological Review*, Vol. 5, pp. 495–504, August, 1940.

[2] See *Success or Failure in Marriage*, by E. W. Burgess and L. Cottrell, Jr. New York: Prentice Hall, 1939.

[3] See "The Conservation of Family Values," Chapter 18, pp. 585–639, of *Marriage and the Family*, by Ray E. Baber. New York: McGraw-Hill Book Company, 1939.

BOOK REVIEWS

PSYCHIATRY FOR THE CURIOUS. By George H. Preston, M.D. New York: Farrar and Rinehart, 1940. 148 p.

In this very readable book, Dr. Preston tells the layman about deviations of behavior. In order to get away from the strangeness and ambiguity of psychiatric terminology, he has made use of the fact that most people are familiar with human behavior as a part of daily living and have common words to describe this behavior. He starts with simple situations that can be easily observed and described without remote abstractions, and builds up to the more complex problems. In support of his text he presents some simple, but effective line drawings expressing the action or situation that he has in mind more vividly than could his words. Thereby he overcomes some of the defects of verbal abstractions. However, he uses these drawings judiciously and does not fall into the difficulties of Gulliver's Laputians, who "carried about them such things as were necessary to express the particular business they are to discourse on" and thus abolished words. His presentation is a modified application of general semantics.

Most of the problems encountered by psychiatry, both gross and minor, are elucidated in this way (mental deficiency omitted). Dr. Preston's discussion of the evolution of inferiority feelings by one-sided comparison is the best application of his method. In dealing with other forms of devious human behavior, he does a good job of interpretation, but his unfolding of the processes of the various deviations is less complete. They are not shown to evolve insidiously, but seem to arise as a choice or design of the victim. In other words, the difference between malingering and less witting deviation is not clarified.

While these omissions are unfortunate, because they are the shortcoming of much that is written about human motivation and mechanism, they do not loom large enough to frustrate the purpose of Dr. Preston's effort. The book is well worth reading, and this or that chapter might well be recommended to persons in trouble by way of helping them acquire a fuller appreciation of behavior.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

PSYCHOBIOLOGY AND PSYCHIATRY: A TEXTBOOK OF NORMAL AND ABNORMAL HUMAN BEHAVIOR. By Wendell Muncie, M.D., with a Foreword by Adolf Meyer, M.D. St. Louis: C. V. Mosby Company, 1939. 739 p.

Dr. Muncie has written a living textbook, using, to illustrate the various reaction sets, well-formulated case material from the Phipps Clinic of Johns Hopkins Hospital. The book follows closely the teachings of that clinic and should be illuminating to those who have not had the experience of working in this setting.

"The text is aimed primarily for the use of students. . . . The material is covered mostly in the obligatory and elective courses in psychobiology and psychiatry at Johns Hopkins."

Some criticism might be made of the book for its emphasis on factual description and its conservative note, but this in any text strengthens the fundamental teaching importance of the work.

The book is divided into four parts. The first chapter of Part I is devoted to the historical and philosophical bases of psychobiology. This is followed by three chapters dealing with the "Student's Personality Study" given in the first-year medical curriculum at Hopkins. The first chapter is quite short and more space might well have been devoted to this phase of the subject, but there is much pragmatic psychobiological material in the chapters on the personality study, which is an excellent guide to study of the person and his normal functioning.

Part II is devoted to abnormal behavior—pathology and psychiatry. Following a short historical account of psychiatric concepts is an excellent outline of methods for psychiatric and neurological examination. Successive chapters deal with the various reaction sets or diagnostic groupings, including the minor and major reactions (psychoneuroses, psychoses). In all of these there is much rich case material, beautifully worked up and well used in the description of each set.

Part III contains 75 pages on treatment procedures, succinctly summing up the approaches and practices employed in the treatment of each of the reaction types.

Part IV, with 175 pages, is devoted to an historical survey in bibliography of the development of the concepts underlying the principal reaction sets. I cannot see that the value of this justifies its inclusion in a textbook, for it lengthens an already long book and increases the cost of publication. I think it is generally agreed that medical texts are prohibitive in price and should be scaled down to decrease their cost. From this point of view, I feel that the last

section would better have been left out of the text, and elaborated upon and used for a separate book.

The book has very real value because of the direct style of the writing, which immediately identifies it as the work of a clinician setting down his methods. It should prove highly valuable to practicing psychiatrists as well as to students, and it contains much that will be of value to medical men in general, as well as to those who are interested in the field of mental health.

HERBERT E. HARMS.

The Colorado Springs Child Guidance Clinic.

THE PUBLIC HEALTH NURSE AND HER PATIENT. By Ruth Gilbert. New York: The Commonwealth Fund, 1940. 396 p.

In this volume Miss Gilbert has faced, as no other author has so frankly faced them before, the dilemmas of the visiting nurse, who must serve those who did not ask her to call and who are not conscious of a need for her assistance and advice.

Here we have revealed to us, in admirably selected illustrative case histories and quotations of characteristic patient-nurse conversations, the full extent to which social concern and inquiry, administrative supervision of a wide variety of the sick and the poor, and the self-confidence of convinced proponents of health promotion through personal appeal, have carried the nurse into homes and across the paths of individuals, particularly of mothers, where her training, as the aid of physicians in bringing healing in sickness, has given her but slight competence.

The question that insistently recurs to the reader is whether the nurse is in the right place at the right time when she must, in the first place, "sell" her personality to the woman of the household—or justify her presence, her intrusion, if you will—when she turns up as the agent of human welfare uncalled and unannounced, and then, when past the barrier of the stranger—or, as it were, of the book or brush salesman—must "sell" her bill of goods, than which there is nothing more complicated and to the average woman at her tubs or sewing machine more remote from daily needs.

The physician and the nurse have too long served in the capacity of attendants upon human suffering and anxiety to be expected, even in the probable interest of higher levels of understanding and performance of human biology, both physical and mental, to become with professional competence the ubiquitous interlocutors of society, the inquisitors of emotional confusions, the salesmen and saleswomen of psychology, the peripatetic peddlers of the latest edition of household and family health.

It is to be assumed that in every instance in which a nurse calls upon a client in order to make inquiry, to learn of the family's status of health or illness, or to contribute to medical management, she is the representative of a physician, private or public, therapeutic or administrative, who is, before the law in the eyes of society, exclusively and entirely responsible in the case. It is not *her* patient, as the title suggests. She shares in service to *the* patient for whom some physician is responsible, or else the nurse is not a nurse, but an agent of sociology, let us say, or perhaps an independent practitioner of medicine, or of education for medical aims, which is not a safe relationship for her to assume.

Miss Gilbert's descriptions of the mental-hygiene problems and opportunities of the public-health nurse—*i.e.*, the visiting nurse—whether she is serving the individual patient or primarily the rest of the community, are admirable. She makes it clear that "public-health nurses are not attempting through the contributions of mental hygiene to achieve a new philosophy of public-health nursing, but more depth, accuracy, and vitality along the lines already established in the community."

In the fifteen topical sections of this challenging book, we pass from the content of mental hygiene in public-health nursing, through the attitudes of the nurse in bedside nursing, the patient's attitudes toward illness—and particularly the emotional reactions of the physically injured or defective—to the picture of mental disease itself as it appears "on the district." Mental hygiene would appear here to be descriptive of the psychology of personal relations, particularly among those disadvantaged by disease.

We are carried on through the teaching of health to the techniques of establishing and building upon a relationship between nurse and patient, reinforced by well-chosen and typically recurring situations, to be met by methods that the wit and thoughtfulness of nurses have made effective. Not only patients as individuals, but groups of them, are presented, each with a classical situation to be solved.

Particularly detailed and substantial is the picture of the maternity patient, perhaps the most nearly physiological of the clients of a public-health nurse.

Chapter V may well be considered a classical text to guide, encourage, and restrain the nurse in that most exquisite art, intervention in the bringing up of another woman's child.

The final chapter, Chapter VI, on relations with co-workers, deals in the main with those perennial preoccupations of directors of nursing services, continuous and consecutive expansion of staff education and the function of supervision, or, as one would wish to have it called, collaboration among the line and staff of the organization.

The bibliography of seventy-seven items is broadly representative and drawn from many fields. A majority of the authors listed are quite innocent of experience in public-health nursing, although writers of competence in the border lands of educational psychology and social economics.

The index is adequate.

One may doubt the wisdom of suggesting that emotion is potent in modifying specific immunity and resistance to the typhoid bacillus, or of assuming as proved that noise equals hours of work as a cause of fatigue. One queries the reasons for calling sickness a "catalyzing agent," or alluding to the time-honored experience of sharing trouble as "anxiety dilution."

Here and there one is inclined to advise protection of the patient against too much management, quite objective, of course, where "letting 'em be" might seem a wiser course.

There is throughout a rather encyclopedic self-confidence in advising as to nurse participation in patient control, as if in a medical vacuum.

In the schedule (p. 346) for analysis of maternity or morbidity visits, one fails to find questions revealing why the nurse made the call. Was she called for by the patient or sent by the organization without patient request?

In regard to achieving a "year-round program of building health" (p. 352), one would wish to know if the nurse is supposed to have cared for the sick thoroughly before she attempts to educate those often uneducable to do what may prove to be the impossible in health performance.

One wonders just what motivation or plan for personal or professional conduct will result from reading the concluding paragraph on page 373, which deals with interagency relationships:

"Here again one sees that attitudes and relationships do not exist by and of themselves, but arise from and contribute to the stage of development of our skill, understanding, and personal characteristics."

Even if successful public-health nursing may be described as "personalized preventive medicine," the impression is easy to obtain from this volume that the majority of the mental-hygiene problems discussed are created in large part by the nurse's invasion of family privacy and by her insistent crusading for other people's health even when she and her presumably superior health knowledge are rejected by the mother or by the family.

An entirely new vision is given of the extent to which nurses poke into family affairs without medical warrant or auspices, take part in situations where they are not wanted, and assume that every latest lecture or leaflet they have read about childhood must forthwith be acted upon.

Among the valued arts of medical practice, within which public-health nursing is included, is knowing when not to interfere.

Fortunate is the physician whose services are sought, for then there is little or no barrier to acceptance of them. The volume before us concerns itself largely with those reticences and reluctances, both of nurse and of the family she visits, when her call is not in response to the conscious need of any member of the household.

HAVEN EMERSON.

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HOSTAGES TO PEACE. By W. E. Blatz. New York: William Morrow and Company, 1940. 208 p.

The author of this book, who is professor of child psychology at the University of Toronto, wants to see a generation bred which will be taught that democracy is something more than just a name and that there is nothing so "instinctive" about war-making that we need feel fatalistic about it. The two problems are related, because democracy is a way of living that particularly encourages rational behaviors, and war is a confession that rational solutions of our problems have not been applied. The author seeks, therefore, to interest parents and educators in the sanest methods of bringing up children. For example, love of country is certainly a good thing; but it no more needs to play the game of jingoists than pride of family must make us fight other families. War is not an instinct, but an activity encouraged by environmental forces that can be controlled. There are no specific objects of fear and anger at birth. To quote:

> "Anger arises when the individual wants something badly enough to exert himself for it; and fear arises when the individual is prevented from withdrawing from a situation which he has interpreted as unfamiliar or undesirable. These two types of emotion form the basis for all later emotional experiences. The later differentiation depends on the experience of the individual." (p. 67.)

> "You can stimulate children to be angry at Jews, Communists, the opposing team, the policeman, anybody. And as these emotions become more unreasonable, they turn into hatred.
>
> "Such emotional fixations have no basis in the actual experience of the child." (p. 73.)

> "It is possible to train a generation of people who will leave their hatreds to their infancy, and will carry into adult life enthusiasm, predilections, varied tastes, and individual cultural standards; whose maturity will be characterized by sanity and tolerance, rather than by hysteria and bigotry." (p. 77.)

Using the happy device of a correspondence between a parent and an educator, the author treats related problems with the same good sense. When we are told that human beings desire to dominate and to submit, the important fact is to see that the satisfactions that children get from either or both types of action are good and worthy. They get such satisfactions in games played in the spirit of sportsmanship. Our whole program of athletics can be lifted up. Let the stress be laid on the joy of struggle rather than on the prestige of winning:

> "In a camp for boys and girls in Northern Ontario, where until recently badges and prizes were given to the children for winning competitions in the various camp activities of swimming, canoeing, sailing, and so on, it was decided to get rid of all trophies and make participation 'its own reward.' To the surprise of the councilors, but not to mine, more children participated in more activities than before. Whereas formerly the children would confine their efforts to an activity in which they thought they might excel and hence win a prize, now we find that the children are willing to try anything, because no matter what their performance, they know there will be no invidious distinction made to crown their efforts, whether excellent or poor. The effort they expend is wholly in terms of the satisfaction they get in acquiring the particular skill to whatever degree they please. There is, of course, competition. There are sailing races, diving exhibitions, and so on, but there is no prize—and no champion. Each child is interested in doing his best, but not to 'beat' some one." (p. 158.)

Dr. Blatz is well aware that views like these by no means guide our most prevalent practices. Nevertheless—and we can imagine him smiling patiently as he writes the words—he ends one of the nine excellent chapters of his book with the words: "At least we can avoid using a false scientific conclusion to aggravate our fears."

HENRY NEUMANN.

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VERBAL INFLUENCES ON CHILDREN'S BEHAVIOR. By Margaret Wilker Johnson. Ann Arbor: University of Michigan Press, 1939. 191 p.

This is an account of a detailed and, in a technical way, a very carefully planned series of experiments to test the effectiveness of the verbal influences of adults upon children. Four different adults carried out the experiments with 84 children in the elementary school of the University of Michigan over a period of three school years, from 1932 to 1934. The children were from two and a half to eight and a half years of age.

One at a time, the children were invited to a room specifically arranged for the experiment. They were asked, "Would you like to come and play games?" Then they were directed in the performance of one "game" after another. The program included 75 different games or situations which were offered in seven separate series.

The children were divided into an experimental and a control group, the individuals of the two groups being comparable in age, sex, and intelligence. A child of one group was given one type of verbal direction, and his mate from the other group a different verbal direction in the same game situation. In this way the influence of verbal directions upon the behavior of children could be tested and compared. The effectiveness of the verbal direction was measured principally in terms of percentages of compliance. In addition, children's voluntary remarks during the experiments were evaluated.

Briefly, the principal findings were as follows: Verbal directions, both reasonable and unreasonable, stimulated behavior significantly as compared with no verbal directions or with questions or requests that permitted the child to use his own judgment. Verbal prohibitions proved to be effective as compared with no prohibitions. Prohibitions seemed to suppress verbal as well as other activity. All children had a higher compliance score for situations in which specific, simple, and direct commands were given instead of general, verbose, and choice requests. Children talked less when the experimenters gave their directions in a verbose manner. Pleasant, hopeful, approving, and unhurried verbal directions were more successful and were responded to with more talking than scolding, depriving, disapproving, and hurrying. Positive forms of prohibition were more efficacious than negative forms, apparently because they stimulated activity away from the one prohibited. Positive and substitute prohibition proved superior to threats, scolding, and negative prohibition. The threatened children talked more than their mates, mainly remonstrating against prohibition.

When the cumulative influence of verbal directions was tested, it was found that greater immediate and less permanent prohibition was followed by more deliberate play, in spite of immediate instruction to work promptly. The children who had been exposed to the more effective types of direction differed from the children of the control group (1) by greater response in a final test of free play, (2) by greater efficiency in solving two problem tests, (3) by better response in an enduring test, (4) by better results when a negative instruction was finally used, and (5) by a higher total compliance score for the final tests.

As to individual differences, greater compliance to verbal directions

was positively related to chronological age, and negatively related to number of behavior problems and number of voluntary comments. All children, but especially the younger ones and those given to behavior-problem tendencies, were aided by the more simple, specific, positive, pleasant, and encouraging verbal expressions.

These results are very interesting in their details, although hardly surprising to experienced and successful educators. They undoubtedly are helpful to teachers and parents as *technical devices* in the endeavor to influence children successfully by means of language. The reviewer doubts whether, in the detached way they are presented, they can be of great help toward understanding children in a deeper sense. Only a few attempts are made to explain why children react in the way they do in these experiments. Furthermore, the child is looked at exclusively as a *re*acting individual, with disregard of the fact that the child can be a spontaneous individual. It seems that the whole experimental situation tends to place a fence around the child which limits spontaneous behavior to the point of exclusion. This increases the validity of the study, as it places the child in a position in which only a minimum of spontaneous behavior will develop and makes possible the child's reaction to verbal influences exercised by the experimenter, with a minimum of other influences entering the picture. At the same time, however, it limits the significance of the findings for education because in the teacher-child or parent-child relationship outside of an experimentally controlled situation, both the child and the adult usually function in a more complex way. This is particularly true for the relationships in present-day progressive education.

Another and even more serious question arises and grows in the mind of the critical reader who studies one chapter after another. The study gives us a large number of tested prescriptions for making children comply by means of language. *Just where this perfect mastery of children through verbal influences has a place in present-day education is not discussed.* The naïve reader may accept it and not do much thinking about it. No questions are raised as to the after-effects of a method that results in the highest degree of compliance of a child with adult requests even if the child's own common sense tells him that they are unreasonable. Nowhere do we find an attempt to relate the problem of Dr. Johnson's study to our knowledge of child personality and child development. And no attempt is made to reëvaluate the findings in the light of present-day philosophies of education.

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PLAY THERAPY IN CHILDHOOD. By C. H. Rogerson, M. D. New York: Oxford University Press, 1939. 64 p.

Following the pioneering work of Hug-Hellmuth (1913), Anna Freud in 1928 published her *Introduction to the Technique of Child Analysis.* Since then, in close succession, a number of contrasting points of view and therapeutic attitudes have appeared. Dr. Rogerson's monograph takes its place in this series as a carefully executed program of experimental and therapeutic play.

After a brief historical introduction, the author reaches the conclusion (p. 15) that it "becomes increasingly clear that there still is a need for objective studies of the play of children which shall be devoted to the observation of what actually happened when theoretical formulations are not given to the child. It is only in this way that we can learn how and in what form the child will spontaneously express his difficulties when allowed to do so in his own terms; thus we may learn what those difficulties are and how their solution may be best attempted."

The author's work was done during the years 1935 to 1937, and for the most part at the child-guidance clinic at Guy's Hospital, London. The technical arrangements included a playroom containing sand, running water, toys (soldiers, guns, a toy house and lavatory, and so on). Each child was told that he "could do as he liked, in fact do anything except break the windows or lights."

The study included 36 children (23 boys and 13 girls), ranging in age from three to fourteen years. The total number of observations varied greatly from case to case. The children were seen at weekly intervals and there were approximately 600 play sessions, distributed over the period of two years. As a rule the parents were interviewed by a social worker and "every attempt was made to modify all possible environmental difficulties." The clinical presentation consists of a discussion of what took place in four "successful deliberately selected" cases, and of a number of items culled from the remainder of the material.

The author emphasizes three significant observations:

1. There was established "an important relationship with the therapist which served as a means for the expression of hostile aggressive impulses."

2. The child expressed his difficulties directly (verbally) or by reënacting a situation (sibling jealousy), or spontaneously employed graphic forms, or engaged in unverbalized self-assertive activities.

3. The majority of the 36 children and all of the 4 "selected" cases showed improvement *without* interpretation.

Dr. Rogerson concludes (p. 62): "Interpretations and generalizations may offer valuable short cuts to knowledge, but they can only be confirmed by patient observation. Interpretations and suggestions speedily reduce the experimental value of the work done. The therapeutic necessity of them has been challenged in this work, and it is felt that their place in treatment should be carefully revised."

The experiences of the reviewer corroborate these factual contributions which have been derived from a method of "non-interpretive" play. In the past, the therapist has overevaluated the importance of interpretation and content because of his own personal needs. It was his interest in proving to others that it was this or the other "mechanism" that was at work, his desire to collect records worthy of publication, his curiosity in seeing what lay beyond the immediate and concrete play presentations, and his wish to get the patient well quickly in order to demonstrate his own therapeutic power, that gave such a high value to the content of every interview and encouraged interpretive techniques. Dr. Rogerson's statements that improvement can and does occur "without the therapist being able to obtain (or find it necessary to obtain) a clear idea of the difficulties in the child's mind," and that "interpretation does not appear to be an essential fact in recovery," are of fundamental importance.

Furthermore, the acceptance of a child for treatment is in itself a significant therapeutic fact. The much troubled parent has found some one to confide in, some one who listens to her and who is willing to take over the responsibility for the care of her "fearful" or "nervous" child. This "calling off of the dogs" of criticism and nagging is appreciated by both parent and child. The patient for the first time finds a friendly adult who encourages his spontaneity and affords him every opportunity for self-expression. It is this relationship in the setting of a play situation that not only invites confidences, but reassures the child that there is some one who likes him well enough to see him at regular intervals.

In the opinion of the reviewer, it is not the playing out of aggressive impulses or fearful thoughts that represents the actual basis of therapy; it is this feeling of being wanted, liked, and appreciated. It is the finding and expressing of one's self in the presence of a friend that is responsible for the change of behavior.

In three out of the four "selected" cases, it is definitely stated that the child had been frequently "scolded and smacked," had "received little affection," or had been "treated harshly." The "why's" of behavior, in such cases, can never play as significant a rôle in altering patterns of behavior as the personal compliment paid by an adult physician to a child patient.

The monograph is an objective and self-critical contribution to the problems of play therapy. It should be read by every one interested in this phase of medicine.

JACOB H. CONN.

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THE DEVELOPMENT OF CERTAIN MOTOR SKILLS AND PLAY ACTIVITIES IN YOUNG CHILDREN. By Theresa Dower Jones. New York: Teachers College, Columbia University, 1939. 180 p.

With a view to developing something in the way of accomplishment standards for the pre-school years, the author analyzed the behavior certain young children exhibited when playing with a doll carriage, a wagon, a dump truck, a kiddie kar, and a tricycle. Twenty-four children—twelve from the higher socio-economic groups and twelve from the lower—were observed repeatedly from the time they were twenty-one months old until their fourth birthdays. Somewhat over half of the forty-minute observation periods occurred when the children were amusing themselves in a standard play room; the rest, while the subjects went about their business in or around their homes. Levels of skill in manipulating, pushing, pulling, and propelling the aforementioned vehicles, as well as in combining play materials, are described.

Some of the experimenter's conclusions are as follows: Repetition of unskilled activities, largely manipulative in nature, was characteristic of the children twenty-one to twenty-four months of age. From twenty-four to twenty-seven months, improvement in muscular control was conspicuous. The merging of activities that previously took place as separate performances seemed to begin when the activities had reached a stage when the child's full attention was no longer needed for their execution. Little merging or integrating of activities, except of a very simple variety, took place before the children were thirty-six months old. By forty-eight months, however, the behavior of the child at any one time frequently seemed to be dominated by a plan—*i.e.*, the performance of certain manipulative skills had by this time become largely secondary to more complex projects or purposes.

A development noted in the behavior involving pushing, pulling, and propelling the vehicles was as follows: (1) pushing and pulling within a limited space, (2) pushing and pulling continuously, (3) attempting to propel, (4) pulling and pushing with control and direction, (5) pulling and pushing the vehicles over obstacles, (6) propelling for at least seven and one-half feet, and (7) propelling

skillfully. The behavior described as the manipulation of the parts of the vehicles likewise showed a developmental trend from mere transitory handling, through a stage characterized by frequent sustained attention to the properties and mechanics of the unit sections, to a level in which the parts were employed in activities more elaborate than demonstrating or discovering how the former worked.

The dump truck, of all the vehicles, commanded the most enduring interest, while the doll carriage had the least appeal. The kiddie kar had much holding power for the younger subjects; the tricycle, for the older.

In general, the children who were accelerated at one level of performance were accelerated at other levels. A correlation of +.50 was found between a mental-test score and age at first success in propelling a vehicle, and of +.52 between the former and the frequency with which the child worked the vehicles on an incline. The girls seemed more interested in combining and arranging materials; the boys, in exploring the mechanics of the objects. In propelling the toys and in the use of the incline, the boys tended to be the more skillful. Emotionality, whether guaged by the amount of laughing or crying the children did, tended to be negatively associated with acceleration in play behavior. Likewise negatively associated with the latter variable were tendencies on the part of the children (1) to be dependent on adults and (2) to be relatively inactive. Positively correlated with superiority in the use of play materials were such variables as the possession of playmates one to three years older than oneself, absence in the home of adults other than parents, the possession of vehicular play materials, and access to an outdoor play space which gave opportunity for freedom in locomotor activities.

Although the investigator believes that experience with toys similar to those employed in her study did improve a child's standing in the group, she nevertheless interprets the behavior sequences and the individual differences she observed largely as functions of maturation. However, she makes the statement "that a more continuous detailed observation would be needed to determine the rôle of maturation and practice." This latter statement seems to me to be somewhat misleading. In the first place, I have never felt that practice and maturation were concepts that could be safely used as alternatives. But even if we grant that they are coördinate, and that Mrs. Jones's conception of them is useful, surely only an experimental approach and not mere continuous observation would throw any essential light on the question of what the two variables contribute to the organization of behavior. No one has as yet been skillful enough to devise a truly crucial experiment. More difficult still would be the discovery of the possible limits of the effects of both variables.

Mrs. Jones's study, it seems to me, has value in providing a rather detailed description of some types of play skills that may be expected of American children of nursery-school age. Relatively little information of this sort has been available. The paucity of cases available for the experimenter's analysis of the interrelationships among a welter of variables curbs one's faith, even though the Fisher techniques have been used, in the meaning of some of the item associations reported. Mrs. Jones seems aware of this limitation of her material.

HELEN L. KOCH.

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THE CHILD AND HIS FAMILY. By Charlotte Buhler, with the collaboration of Gertrud Falk, Sophie Gedeon, and Gertrud Horther. Translated by Henry Beaumont. New York: Harper and Brothers, 1939. 187 p.

At the outset, the authors state that the purpose of the investigation described in this monograph was methodological only. There is no attempt to present new facts in the field of family relationships. Instead, the authors have confined themselves to the description of a procedure whereby "problems which have hitherto been approached only descriptively" may be subjected to exact methods of study.

The procedure in question is essentially that of semi-quantitative observation which has been extensively employed in studies of nursery-school children in this country, though it has been less frequently utilized in the analysis of home and family life. As reported by Buhler and her associates, it consisted of having a trained observer make regular visits at semi-weekly intervals to the home to be studied, varying the time of the visit from one occasion to another so as to secure a sample that would be as nearly representative as possible of the usual activities of the family. No notes were taken during the visit, but immediately upon its conclusion a complete account was prepared of everything that had been observed, including verbatim records of conversations, as far as these could be remembered.

In support of their belief that failure to take notes at the time did not materially interfere with the basic accuracy of the records, the authors cite the results obtained by having two observers visit a home simultaneously and make independent records, which were later compared to ascertain the extent of agreement. It is stated that in four such sets of comparisons the agreement ranged from 66 to 83 per cent, "which may be considered adequate since 60 per cent constitutes the permissible minimum." Most American workers would hardly be satisfied with so low a level of accuracy, especially since the percentages appear to be based upon the mere proportion

of recorded "events" that appeared on both records. The extent of the *descriptions* of these "events"—which is the real point at issue, since it is with the quantification of these descriptions that the study is primarily concerned—is not reported.

In all, seventeen families were studied, of which the present report is concerned with only six. For each, not less than fifteen hours of time was spent in observation of situations involving at least two members of the family group. At least an equal amount of time must have been required to tabulate and summarize the results.

The method of analyzing the data consisted for the most part of counting the number of observed contacts between any two members of the family and classifying these according to their purpose, the methods used for initiating them, the manner of response, and so on. The results for each family were summarized separately. By means of graphic representation, the marked differences in frequency and type of interfamilial associations were brought out. In reporting the findings, documentation in the form of anecdotal accounts of individual incidents is generously supplied.

The question that immediately occurs to the critical reader in search of new tools with which to improve and widen his professional activities is likely to narrow down to this: Is the method one that will repay its cost? To answer this question, it is necessary to consider the purpose for which the results are to be used. Certainly the amount of time required to secure reasonably dependable results is far too great to fall within the limitations set by even a fairly generous budget if the purpose is that of pure research.

As a teaching device, however, the plan unquestionably has many possibilities. There, one is less concerned with the accuracy of the particular facts, since the primary aim is to clarify and emphasize the general principles that they illustrate. For this purpose, the striking differences between families shown in Dr. Buhler's charts with respect to such matters as frequency of evasive responses on the part of parents, number and type of contacts between different members of the same family, and many other matters of the same general sort, should be very illuminating.

The procedure might also find a place in the training of students in social work, parent education, or other areas in which the case-study method is used. The use of this method in the study of one or two individual families would undoubtedly help the student to know what to look for when observing behavior, and should likewise increase his realization of the importance of small matters through providing a quantitative demonstration of the astounding

total that may be attained by the continual piling up of behavioral minutiæ of a similar type.

In some behavior clinics, in which the case load is low enough to permit workers to spend the necessary time per family, the use of the method for cases of special interest might also prove both informative and suggestive of new modes of approach to the problems involved.

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THE PSYCHOLOGY OF HUMAN CONFLICT. By Edwin R. Guthrie. New York: Harper and Brothers, 1938. 408 p.

Any one who takes up this book will be at once impressed by the clear and lucid style in which it is written. This is fluid, direct, and easy, with a pleasing avoidance of the complicated constructions used by so many authors as a device to parade their so-called erudition. The result is a much more readable book than is usually met with in the field of psychology.

Professor Guthrie apparently has set for himself the task of developing a descriptive account of human behavior and motivation, including abnormal behavior, in terms of a psychology built up from the concepts of stimulus, response, and associative learning. The entire presentation is, therefore, subordinated to the elaboration of these concepts and their multitudinous applications to all phases of life. Several consequences naturally follow. One cannot but feel that the account is somewhat oversimplified in places. Questions that might lead into philosophical considerations, and thus lose the objectivity which the author seems to value, are avoided or are passed over with rather superficial definitions. For example, mind is defined as the ability to improve adaptive behavior with experience. The concept of the unconscious is readily sidestepped by equating the terms "unconscious" and "unarticulated," with little attempt at logical justification. These topics, among others, appear to be treated in a manner that can hardly be accepted by all psychologists.

Nor does the reviewer feel that the attempt to be objective is entirely successful. It is, naturally enough, often necessary to use terms that originally had a subjective meaning. Many of these—such as "mind," "personality," "desire," "motive," "voluntary action" (to mention only a few)—are adequately redefined so that it is quite clear what is meant by them. But aside from this, one finds the author again and again shifting from an objective to a subjective description. Perhaps this is clearest in the discussion

of daydreams and phantasy, where subjective terms and points of view are apparently utilized without redefinition. The reader wonders whether he has been too stupid to see an obviously implied objective meaning of these terms, or whether such a new definition is too elusive to be attempted. As is common in extensive behavioristic descriptions, sub-vocal speech movements play an important part in the discussion.

The main argument of the book consists of an unusually clear exposition of the nature of associative learning, and of the many factors that influence such learning. A great deal of stress is laid upon the concepts of inhibition and reinforcement. These two concepts are applied both to the action of the environment upon the individual and to the effect of his own somatic changes upon behavior, particularly in emotional states. There is a marked tendency to lean upon physiological concepts for explanatory purposes. Muscular and glandular changes are always preferred for this end to any account in terms of the total life situation. The whole account, despite the tendency to oversimplification, is logical and well worked out.

The latter part of the book is an account of the abnormal types of behavior, particularly the neuroses and the so-called nervous breakdown, in terms of the system already elaborated. A great deal of use is made of the ideas of Janet. Freudian observations are accepted, but the psychoanalytic system of explanation is rejected, partly because it involves a spurious reading of adult motivation into infantile life. The importance of habit systems and their manipulation is, of course, emphasized, for it is a logical link in a chain built out of the principle of associative learning. The psychoses are treated in rather brief fashion, psychotic behavior being attributed mainly to abnormalities of brain structure, either now known or to be discovered at some time in the future.

Taken as a whole, this work is a most refreshing contribution to present-day psychology because of its avoidance of excessively complicated formulations. The account of abnormal behavior in terms of learning and habit places the essential facts clearly before the reader, and suggests rather direct ways of handling them by means of reëducation. Surely the scientific principle of parsimony requires that these simple explanations be given adequate trial before one resorts to those more complicated. From this point of view, the book is one to be read by all workers in the field of human behavior —and to challenge the thinking of many.

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FIGHTING FOR LIFE. By S. Josephine Baker, M.D. New York: The Macmillan Company, 1939. 264 p.

Fighting for the life of little children is a grim business, but Dr. Baker has managed to have a lot of fun as a front-line soldier in that battle. A distinguished pediatrist who pioneered as director of the world's first bureau of child hygiene, she tells her story with gusto, human warmth, and a disarming frankness. The result is an autobiography that combines entertainment and enlightenment in a most unusual degree.

Born in Poughkeepsie of a well-to-do family some sixty years ago, the author spent a gay and lively childhood that apparently was one long round of summer visits and winter sleigh rides and jolly parties. This idyllic life ended abruptly for Josephine Baker at sixteen, when her father's death left the family in straitened circumstances, and she was faced with the necessity of finding a means of livelihood. She decided on a medical career, and entered the Women's Medical College in New York City. It was a daring decision to make, since women physicians were still rare, and they had to fight their way through formidable opposition. It is ironic that the one subject that Josephine Baker flunked in medical school was precisely that which formed the foundation for her later lifework—a course in the "normal child."

Obtaining her medical degree in 1898, Dr. Baker started practice in New York, where she came face to face with the terrific prejudice against female doctors. After several years of hardship, ministering to a meager and ill-paying clientele, she became a medical inspector in the city department of health, at the munificent salary of $30 a month. At that, she had to resort to "political pull" to get the job. Dr. Baker presents a striking portrayal of the political corruption that at the turn of the century ate deeply into public-health services, as into all other branches of municipal government.

When the Bureau of Child Hygiene was established in the New York City Department of Health—the first of its kind anywhere—Dr. Baker was appointed its director. If a "lady doctor" was a rarity in those days, one in an executive position was even rarer. The name on the letterheads read, "Dr. S. J. Baker," to disguise the presence of a woman in a responsible administrative post, and of course the director had to wear mannish clothes as protective coloration. When her appointment was announced, all the male medicos under her sent in their resignations in protest, and Dr. Baker had to resort to the most artful devices to persuade them to remain.

Pioneer work had to be done in developing the school as a major child-health center, in educating parents, in integrating general sanitation with child hygiene, and in carrying the fight for life into the darkest slums. The infant mortality rate was frightfully high;

in summer babies died like flies. One-third of the mortalities in New York City were children under five, and one-fifth were babies of less than one year of age. It was unusual to walk through a tenement district without encountering at least one "little white funeral."

One of Dr. Baker's first accomplishments was to institute an experimental system of district nursing in the summer season, when 1,500 babies were dying weekly. A "complicated, filthy, sunless, and stifling nest of tenements" on the lower East Side was selected as the demonstration district, and during that first summer that district had 1,200 fewer baby deaths than in the previous summer, while the death rate elsewhere remained unchanged. Dr. Baker and her associates had found one means of large-scale baby saving; prevention had paid beyond their wildest dreams.

Clinics were established in schools for the discovery and early treatment of contagious diseases; baby health centers were set up throughout the city; district nursing was expanded; mothers were educated in infant care; sanitary health measures were introduced and enforced. Meanwhile, of course, momentous discoveries regarding the origin, nature, prevention, and treatment of various children's diseases gave great impetus to the progress of child hygiene.

Nevertheless, standards in child hygiene that are now taken for granted everywhere were introduced with the greatest of difficulty. Always present was the element of inertia that resists innovation of any kind. Political hurdles had to be overcome, especially during graft-ridden administrations which eyed the health services avidly for choice patronage plums. At times the bitter opposition of medical men, organized and unorganized, had to be met. An almost incredible story is related of a petition, signed by some thirty-odd Brooklyn physicians, complaining that the Bureau of Child Hygiene was ruining medical practice by keeping babies well, and demanding that the mayor abolish it in the interests of the medical profession. The protest was forwarded to Dr. Baker, who hailed it as an impressive testimonial of the bureau's effectiveness.

At times various municipal authorities found themselves working at cross-purposes. To cite a minor instance, when health officers began to insist that parents keep children with contagious diseases out of school, truant officers promptly ordered the children to return to school at once, under threat of dire penalties. Little wonder that some of the harassed immigrant parents came to regard the public officers as slightly unbalanced mentally.

The fight for life was not without its humorous side, and Dr. Baker's book is rich in anecdotes illustrating this lighter aspect. She pays

high tribute to the generally intelligent coöperation of immigrant mothers in the movement to develop child hygiene. However, she does manage to relate some comic stories about the early days of health work in the schools. There is the gem about the teacher who sent a pupil home with the suggestion that he needed a bath. Came a prompt reply from the mother: "Dear Teacher, My Ikey aint no rose. Don't smell him—learn him." Another tells of the note received from a mother to whom an inquiry had been sent about a Schick test for her son at the time when Rudolph Valentino was thrilling the nation's womanhood in *The Sheik*. "Dear Teacher," the mother wrote, "I've read the book and I've seen the movie and I don't want my boy to have none of it." Then there was the hapless school nurse who brought down on her head a parent's righteous wrath by abbreviating "nutrition" so that the pupil's report read "poor nut."

'Tis an ill wind that blows no good, and the World War proved a potent stimulus to child welfare by making the nations conscious of the problem of conserving man power. Dr. Baker notes the rapid increase of child-guidance bureaus throughout the country. Up to 1914, the lead of New York City had been followed in only five states; during the war and immediately after, such bureaus sprang up everywhere. By 1923, Dr. Baker was able to carry out her self-imposed vow to retire from her post when these public agencies had been established in every state. It was during the war, incidentally, that she coined that effective propaganda slogan: "It's six times safer to be a soldier in France than to be born a baby in the United States."

The author's whole-souled devotion to child hygiene did not prevent her from participating in a number of progressive movements in behalf of various underprivileged groups. Her book also includes some interesting side lights on the suffragette movement, in which she participated.

Dr. Baker is no sentimentalist. In fact, although a deep concern for her fellow humans always pervaded her work, she insists that her approach was a hard-boiled one. Many of her accomplishments were achieved by the application of good, old-fashioned common sense, and the tempering of a characteristic stubbornness with tact when necessary.

Like many of her colleagues, Dr. Baker eventually visited Soviet Russia to see with her own eyes what was being done there in the field of public health. A very interesting chapter of her book presents the defects and virtues of Soviet health activities.

The concluding chapter sums up the author's ideas on such sub-

jects as birth control, socialized medicine, and conflicting theories in child hygiene. Dr. Baker finds encouragement in the fact that the infant-mortality rate in the United States is now half what it was thirty years ago, and that maternal mortality has also dropped considerably, although in both instances the rate is not what it could and should be. She poses the question whether it is worth while to bring children into this insecure and troubled world of ours, and even whether it is good to keep them alive and well once they are here. "I have faith in the ultimate decency of mankind," she concludes. "I believe this salvaging of human life has been worth while."

"A glorious, an exhilarating, and an altogether satisfactory life," is Dr. Baker's evaluation of her personal history, which is not at all to be regarded as a smug statement. The reader of her book will agree with her, and will add that it was a remarkably useful life, and a life splendidly presented in these pages.

ALBERT DEUTSCH.

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NURSING MENTAL DISEASES. By Harriet Bailey. Fourth Edition. New York: The Macmillan Company, 1939. 264 p.

This is a new edition of a valuable and popular textbook for students of nursing. In her preface Miss Bailey says that she has tried to include more description of nursing procedures, more information as to what to say and do. That is timely. (May we hope some day for a textbook that will be devoted almost entirely to procedures, leaving descriptions of conditions to the lecturer and demonstrator?) There has been some rearrangement of chapters, on the whole with strengthening emphasis, although the reason for the change is said to be that there are corresponding changes in the official classification of the American Psychiatric Association.

Since the general scheme of the book is unchanged, comments on the content will be of little interest to those who have read reviews of previous editions. The first chapter gives a good account of the care of the mentally ill, interesting and easy to read. More space has been given in this edition to Dr. Meyer's influence, and additional references have been made to teaching hospitals and to the Allentown project for children. A chapter on the legal aspects of mental diseases gives the accepted view of various procedures. One may remark that it is not certain that a mentally sick patient could not make a

valid will. New York is widely given credit for sending nurses from the hospital to bring in committed patients; some other states do the same thing, for instance, Idaho. The general statement that patients during parole are visited by a social worker has unhappy exceptions in several states.

The chapter on personality development is of some significance, but does not give one the feeling that a full picture of this very intricate process has been, or perhaps can be, presented in short compass. The causes of mental disorder are brought together in short space. Alcoholism receives perhaps more than its share of criticism. Among the alcoholic psychoses the description of delirium tremens has been rearranged. It deserves a central heading comparable to "Korsakow's psychoses." A chapter on the symptoms of mental disorders is very valuable. The function of judgment might be placed as No. 5 under the intellectual functions. The discussion of disorders of the emotions might well be expanded. The behavior chart on page 49 is poorly reproduced. *Qualifications for Mental Nursing* is a useful chapter although one may question whether the procedures so well described are really "qualifications." One notes that mercury and arsphenamine are gone and tryparsamide has come in.

In Chapter VIII, general paresis has been moved ahead of the traumatic and other disorders. This is an improvement, although the great number of brain injuries that occur nowadays makes the recognition of behavior difficulties following head trauma important for work in the home and in the general hospital. The section on the manic state has been greatly improved. One can only wish that all manics might get nursing such as is described here. A chapter on dementia praecox includes a presentation of insulin and metrazol therapy, both of which procedures call for very competent nursing.

In the chapters on therapeutic measures and on physiotherapy there is the same fine emphasis on treatment that extends all through the book. The Brand bath is now gone. With the exception of a good exposition of hydrotherapy there are no detailed descriptions of procedures in the chapter on physiotherapy. The chapter on mental hygiene uses the word "neuropathic," which is of doubtful integrity.

In the glossary, Kraepelin has been shifted from Austria to Germany. The bibliography has grown. There are other changes, too, and this helpful volume will continue not only to inform, but also to inspire the young nurse.

SAMUEL W. HAMILTON.

United States Public Health Service, Washington.

PERSONAL AGGRESSIVENESS AND WAR. By E. F. M. Durbin and John Bowlby. New York: Columbia University Press, 1939. 154 p.

As its preface states, this essay appeared originally in 1938 as part of a symposium on "War and Democracy," of which Mr. Durbin was one of the editors. The present volume consists of two sections, the first fifty pages being devoted to a discussion of three theories of war, while the remainder of the book presents examples and quotations from psychoanalytic studies of aggression, reports on aggression in monkeys and apes and in children, and data on the subject from the writings of various anthropologists.

The authors believe that an analysis of the causes of a particular war are a task for the historian rather than the psychologist and they attempt merely "to describe and analyze the general psychological forces lying behind the timeless and ubiquitous urge to fight and kill." They dispose of the economic and nationalistic theories and claim that war occurs because fighting is a fundamental tendency in human beings. They emphasize that there is nothing original in this theory—that it is only enlightened common sense. But in spite of their belief in "an underlying willingness to kill," they share a faith and a hope that something can be done about it, stating that "the impulses to peace are more powerful than the impulses to war." Yet elsewhere they tell us that "the majority of human beings are prepared to fight, that fighting is a form of behavior fundamentally natural to them." Thus they seem to blow both hot and cold, presenting the universal conflict between instinct and ideal, but on the whole with a shade of emphasis on the side of hope for a solution. Their discussion as to how this might be achieved is fair and reasonable.

It does not seem to this reviewer that the essay contributes anything of note to our understanding of war, nor as we have said, do the authors claim any novelty for their views. One must look for the merit of the book along other lines. It can be well recommended to the student of human behavior as a literary introduction to a study of the aggressive impulses and reactions in the individual. The final section, entitled *War between Civilized Communities,* is all too brief, since this is the problem with which we are presumably most concerned. This section is taken up with quotations relating to the anti-Semitic persecutions in Germany.

DAVID SLIGHT.

University of Chicago.

NOTES AND COMMENTS

Compiled by

PAUL O. KOMORA

The National Committee for Mental Hygiene

NATIONAL DEFENSE IS THEME OF NATIONAL COMMITTEE'S ANNUAL MEETING

The National Committee for Mental Hygiene held its Thirty-first Annual Meeting on November 14 with a luncheon at the Roosevelt Hotel in New York City. About five hundred members and guests attended the meeting, which signalized the inauguration of the National Committee's fourth decade of work. A special scientific program was arranged to mark the event, in which nationally known leaders in psychiatry and mental hygiene, education and social work participated. Dr. Adolf Meyer, President of the National Committee, presided at the luncheon, and Dr. Edward A. Strecker, Chairman of the Scientific Administration Committee, conducted the scientific program, which was devoted largely to a consideration of mental-health issues in the emergency.

Dr. Harry Stack Sullivan, President of the William Alanson White Psychiatric Foundation, gave the keynote address, in which he showed how psychiatry can be utilized in the service of national security, and discussed the rôle of the psychiatrist in building up the armed forces, in industrial mobilization, and in the promotion and protection of military and civilian morale. Next was a talk by Dr. Clarence M. Hincks, General Director of the National Committee for Mental Hygiene of Canada, giving an illuminating picture of mental-health war work in that country; after which Dr. Harry A. Steckel, Chairman of the Military Mobilization Committee of the American Psychiatric Association, in a paper read for him by Dr. Ira S. Wile, made a progress report on psychiatric organization in connection with the medical-preparedness program in the United States.

Other speakers, who dealt both with the emergency and the long-run aspects of organized mental-health work in relation to education, the family, and society in "our changing world," were Harry A. Wann, Superintendent of Schools of Morris County, New Jersey; Stanley P. Davies, Executive Director, Community Service Society of New York; Dr. James S. Plant, Director, Essex County Juvenile

Clinic, Newark, New Jersey; and Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene.

Selective Service System Moves to Eliminate Mentally Unfit

Medical Circular No. 1, issued by National Headquarters, Selective Service System, Washington, November 7, 1940, is aimed at the exclusion of the mentally unfit from military service. It is addressed to all state directors of selective service, chairmen of local draft boards, examining physicians, members of medical advisory boards, and others engaged in the task of selecting men for the armed forces of the United States for service and training.

Profiting from the experience of the last World War, and alert to the importance of mental as well as physical fitness among those enrolled in the national army, the selective-service officials are determined that the men chosen for induction shall be those "clearly capable of undergoing the physical demands and the mental stresses of military service." They have, therefore, undertaken to direct and instruct the selective-service personnel engaged in the induction process, to the end that mentally defective recruits, as well as those physically defective, shall be eliminated.

Military and naval experience, Director C. A. Dykstra points out in the circular, is in favor of excluding from the armed forces "all persons discovered to have mental or personality handicap of any material degree," on the premise that such men will be unable "to manipulate the circumstances of army life to create for themselves the necessary protective situation and will ultimately break down." Not only will they break down, he adds, "but in the process, they will prove a disturbing and disruptive influence in their army unit and be detrimental to its discipline, its efficiency, and its general morale."

It is intended that the circular should be of assistance to the physicians of local boards in detecting or suspecting the existence of mental disorders in the men who are examined. Since the great majority of these physicians are not psychiatrists, it was apparent that practicable methods of examination would have to be outlined that would enable them to recognize incapacitating mental and personality factors in the registrants who come before them.

Accordingly, a "Minimum Psychiatric Inspection" syllabus, prepared by the William Alanson White Psychiatric Foundation, has been incorporated in the circular to guide the physician in his examinations. The examiner is authorized, on the basis of this guide, to reject any recruit deemed in his judgment to be unfit or, in case of doubt as to the mental state of a registrant, to refer him to the psychiatrist of the medical advisory board for further examination.

Governor Lehman Appoints Commission to Study New York State Hospitals

Governor Herbert H. Lehman has recently appointed an unofficial commission to survey the mental-hospital situation in New York State. Motivating this action is the concern of the authorities over the mounting economic burden of caring for the many thousands of patients in the state's mental institutions, which this year is costing the taxpayers nearly $35,000,000, in spite of the increasing recoveries that are resulting from great advances in medical treatment and improved methods of care. In the last eight years the number of patients in the twenty-seven mental hospitals of the state has grown from 64,000 to nearly 90,000, and the institutional population continues to grow at the rate of about 3,000 a year.

To combat this increase, and, if possible, to reverse the present trend, the commission will study ways and means of reducing the number of admissions and increasing the number of discharges, with special reference to such possibilities as accelerating the rate of paroles; enhancing the effectiveness of insulin, metrazol, and other forms of shock therapy; promoting a wider use of out-patient clinic and social-service facilities; extending the boarding-out care of patients; securing earlier diagnosis and treatment; and speeding up scientific research. Preliminary plans for the study have been formulated by Homer Folks, Secretary of the State Charities Aid Association, who is chairman of the commission. The ten other leaders in psychiatry, mental hygiene, and social service, who compose the commission, are: Dr. Karl M. Bowman, Director, Psychiatric Division, Bellevue Hospital, New York City; Dr. Clarence O. Cheney, Medical Director, New York Hospital, Westchester Division (Bloomingdale), White Plains, New York; Miss Hester B. Crutcher, Director of Psychiatric Social Work, Department of Mental Hygiene, Albany; Stanley P. Davies, Executive Director, Community Service Society of New York; Dr. William J. Tiffany, State Commissioner of Mental Hygiene, Albany; Dr. Lawrence Kolb, Assistant Surgeon-General, United States Public Health Service, Washington; Dr. Frederick W. Parsons, former New York State Commissioner of Mental Hygiene, New York City; Dr. William L. Russell, consulting psychiatrist, Payne Whitney Psychiatric Clinic, New York City; Dr. Nolan D. C. Lewis, Director, New York State Psychiatric Institute and Hospital, New York City; and Dr. George S. Stevenson, Medical Director, The National Committee for Mental Hygiene, New York City.

Commissioner Tiffany Appoints Department Secretary

On November 4, Commissioner William J. Tiffany announced the appointment of Clarence H. Pierce, of Buffalo, as secretary of the New York State Department of Mental Hygiene. Mr. Pierce succeeds the late Lewis M. Farrington, who served in this post for nineteen years until his death last summer. Mr. Farrington had risen to this responsible position through successive promotions in the New York State hospital service which he entered in 1905, and the *Mental Hygiene News* paid high tribute to his skill in conducting the affairs of the department and the distinction with which he served under several commissioners.

The new incumbent brings to the office a valuable combination of qualifications and experience gained in the field of public welfare and administration. After graduating from the University of Michigan in 1931, Mr. Pierce attended Western State Teachers' College, Kalamazoo, and, subsequently, the New York School of Social Work. From 1934 to 1936, he served in the Pennsylvania Emergency Relief Bureau, and in 1937 he joined the faculty of the University of Buffalo School of Social Work, where he taught for three years. In 1938 he was appointed executive director of public assistance in the Erie County Department of Social Welfare.

National Conference on Family Relations

The National Conference on Family Relations held its Third Annual Meeting at the Stevens Hotel in Chicago on December 26-28, under the presidency of Dr. Adolf Meyer. The program was organized around the theme, "Trends and Resources in Family Living," with special reference to the significance of the national emergency from the point of view of the family. Meetings dealing with special topics were conducted at the conference by national committees charged with the study of such phases of the subject as family law and its administration, marriage and family counseling, and the problems of youth; and at the general sessions of the conference the topics of discussion were trends in family living, the family in wartime, and community resources for the conservation of the family.

The National Conference on Family Relations was organized in 1938 "to advance the cultural values that are now principally secured through family relations for the advantage of the individual and the strength of the nation." It encourages coöperative study and research in scientific, medical, educational, social, and other fields concerned with family welfare, and works through regional, state, and local conferences formed for this purpose. Committees or conferences on

family relations are now organized in nearly all of the forty-eight states, and as part of its educational program, the National Conference publishes *Living,* a quarterly journal. Inquiries as to membership and subscriptions should be addressed to Miss Mary K. White, Executive Director, 1126 East 59th Street, Chicago.

Research Council on Alcohol Holds Annual Meeting

Several hundred members and guests, including leaders in medicine and psychiatry and representatives of business, civic, and social groups, attended the annual meeting of the Research Council on Problems of Alcohol held at the Commodore Hotel in New York City on October 15.

The proceedings opened in the morning with a series of eight separate round tables devoted to informal discussion of such topics as the methods now used by medical practitioners in treating alcoholics; the rôle of clergymen and lay advisers in helping alcoholics; the relation of police departments, courts, and correctional institutions to the alcoholic; the interest of alcoholic-beverage-control boards in the reduction of alcoholism; and the hospital, clinic, social-work, public-health, and research aspects of the problem. The chairman of each group conference then presented a summary of findings at the luncheon session, at which the principal addresses were made by Everett Colby, attorney at law, and H. F. Willkie, Vice-President of Joseph E. Seagram and Sons, Inc. Dr. Winfred Overholser presided at the luncheon, and presented the annual report of the board of directors.

The council invites all interested citizens to inform themselves regarding this new scientific program for combating alcoholism, the nation's "greatest disease enemy not being systematically attacked," by writing to its offices at 60 East 42nd Street, New York City.

Dorothea Lynde Dix—Candidate for the Hall of Fame

The friends of Dorothea Lynde Dix continue to hope that she will before long be given a place in New York University's Hall of Fame in the growing company of great Americans upon whom this high honor has been bestowed during the past forty years. Disappointed over the failure of the electors to name her in the Ninth Quinquennial Election held on November 14, they are nevertheless gratified that Miss Dix received a substantial number of votes, which placed her well in advance of the majority of the 141 famous men and women entered on the ballot.

Although little known to the American people of this generation—a recent biography of Dorothea Dix refers to her in its subtitle as the "Forgotten Samaritan"—there is no dearth of historical testimony to the remarkable achievements of this remarkable woman. The mental-hygiene movement, founded twenty-two years after her death, has its roots in the humanitarian soil prepared by her mighty reforms in the care and treatment of the insane and the feebleminded, and the present resurgence of interest in her life and work bids fair to win for her the recognition she so richly deserves. In the balloting in the elections of 1905 to the Hall of Fame, under the heading "philanthropists and reformers," her name led all the rest, and she received a large vote in the four following elections. Let us keep her name before the public mind and bring her selfless exploits in behalf of the mentally afflicted to ever wider attention, until she is selected for this honor, as no doubt she eventually will be.

"The Cedars of Lebanon"

An urgent plea on behalf of The Lebanon Hospital for Mental Diseases near Beirut, in Syria, reaches us from England, principal source of support for this unique institution which serves the sorely afflicted in the Near East. For forty years Lebanon Hospital has catered to men and women of many races, nationalities, and religions, often including English and American invalids. It is an excellently equipped modern hospital beautifully situated in the foothills of Mount Lebanon, looking across the Plain of Beirut to the Mediterranean, with fourteen spacious houses and numerous other buildings on its thirty-seven-acre tract. Its bed capacity was recently raised to five hundred to accommodate the increasing number of its patients. It is staffed by three physicians and eighty Syrian nurses, and administered by a group of European workers headed by Dr. Stewart Miller, who is lecturer in mental and nervous diseases at the (American) University of Beirut. For many years all fourth-year medical students have taken his courses in psychiatry to equip them for practice in posts all over the Near East. During 1939, there were 777 patients under treatment, of whom 137 were discharged as recovered or improved.

War conditions make it exceedingly difficult to keep the hospital going, what with a shortage in funds, an immensely augmented population in the Near East, and the increasing stress and strain of life, which make its services all the more indispensable and render imperative quickened support from the several countries on which the instition has depended ever since its establishment. Its mainstay, the central committee in London, is hard pressed to continue its up-to-now unfailing help, as we can well appreciate, and it turns to its

friends in America and other parts of the world for a lift in its present need. We bespeak for Lebanon Hospital, whose noble work is not unfamiliar to many in this country, a generous response to its distress call at this time. Donations should be sent to the central office, Drayton House, Gordon Street, London, W. C. I. We quote from the moving appeal addressed to us by the secretary, Miss Hilda Fox:

> "You can imagine that at present, with a tremendous income tax and demands on all of us from many other sources, it is extremely difficult to get money for even this sort of overseas 'missionary' work which appeals to us in England so very much. And so we ask you in America to offer a helping hand during this time of our national difficulty when, indeed, we are fighting for every sort of international and humanizing piece of work and culture as well as for our own existence. Do please help to keep this splendid work undiminished, and support the staff during these strenuous years by the knowledge of your interest in them, shown by tangible aid."

State Society News

Illinois

The Illinois Society for Mental Hygiene has appointed Dr. John Chornyak as its medical director to succeed Dr. Conrad Sommer, who is now Superintendent of the Division of Mental Hospitals of the Illinois Department of Public Welfare. Dr. Chornyak comes to Chicago from Pittsburgh, where he was psychiatrist to the juvenile court. He received his medical degree from the University of Pittsburgh in 1926, and in 1933 entered the field of neurology and psychiatry, serving for a time as a fellow at the Judge Baker Guidance Center in Boston. In 1936 the University of Pittsburgh conferred on him the degree of D.Sc.

Massachusetts

"Ever-watchful of the mental health of the community," is the slogan of the *Mental Health Sentinel,* new mouthpiece of the Massachusetts Society for Mental Hygiene, the first issue of which appeared in October. Superseding the *Monthly Bulletin,* which has been published by the society since 1922, the new periodical is a quarterly magazine, handsomely printed and illustrated, edited in a more popular vein, and directed to a larger audience than the former publication. It is intended to appeal "not only to those professionally interested, but to all citizens of the state." The subscription rate is one dollar a year. The Massachusetts Society is to be congratulated on thus striking out in its efforts to bring the teachings of mental hygiene to a wider public, and we wish the *Mental Health Sentinel* long life and success.

Michigan

The Michigan Society for Mental Hygiene held its Fourth Annual Meeting in Grand Rapids on October 10-12, joining with the Michigan Welfare League in providing a program of unusual scope and interest, in which prominent leaders in various fields related to mental hygiene participated. Session discussions extended to such timely topics as the psychiatric aspects of the national-defense program, mental hygiene in industry, the relation of religion to social work, problems of adolescence, public attitudes toward mental illness, mental health in the schools, and speech-correction therapy. Full reports of the conference sessions appear in the Michigan Society's bulletin.

New York

The New York State Committee on Mental Hygiene reports success in its efforts, begun in 1938, to secure a community mental-health service for Suffolk County. The board of supervisors of the county, on October 29, authorized an appropriation of $17,525 to establish such a service in the county health department, a step that received the commendation of Surgeon-General Thomas Parran, Jr., of the United States Public Health Service, because of the uniqueness of the venture, since this is probably the first instance in the country in which a county health department has assumed complete responsibility for a psychiatric clinic. The clinic will be staffed by full-time personnel, consisting of a psychiatrist, a psychologist, two psychiatric social workers, and a secretary. Many officials and civic leaders in the county promoted the enterprise, and credit is given by the New York Committee especially to the County Council of Social Agencies, to the League of Women Voters, and to Dr. William Ross, president of the county board of health, who said: "We are just as much obligated to carry on a program for the prevention of mental illness as the one we have engaged in for the prevention of physical illness."

Virginia

The Fourth Annual Meeting of the Mental Hygiene Society of Virginia was held at the Richmond Academy of Medicine on October 31. A feature of the meeting was an evening address by Dr. Lawrence Kolb, Assistant Surgeon-General, Mental Hygiene Division, United States Public Health Service, who spoke on "Mental Health and National Defense." The afternoon session was devoted to the general subject of "The Adolescent," with representative spokesmen of mental-health work in the state taking part. A general discussion period followed the presentation of papers. The influence of the Virginia Society's work in the state is reflected by the growing interest in mental hygiene among the medical profession, indicated, among other developments, by the fact that the *Virginia Medical Monthly,* official

publication of the state medical society, made its October issue a "mental-hygiene number."

Wisconsin

"There is a crying need for public addresses couched in terms that quiet superstitions and fears and arouse confidence and courage to face problems intelligently. . . . Superstition and fear still abound in Wisconsin. . . . The patient restored to the community is regarded with a fearful curiosity. The child that is 'queer' is treated in such a manner that he becomes more queer. We need reinterpretation of our data in terms that are shorn of mystery and fear, that emphasize the learning aspect of treatment."

We quote from the annual report of Dr. Esther H. de Weerdt, Executive Secretary of the Wisconsin Society for Mental Hygiene, which was published in the society's October bulletin, and which illustrates, as well as anything we have read lately, what the educational responsibilities of mental-hygiene societies are, and how an alert group of professional and lay workers in one state is facing up to these responsibilities. For example, in connection with plans to rewrite the state's commitment laws, the report recognizes the need for long and intensive educational effort, with legal, medical, and lay groups, before public and legislative opinion is ready to accept the changes dictated by modern psychiatric conceptions of the care and treatment of the mentally ill. "It would be disastrous," Dr. de Weerdt writes, "to place a law on the statutes which will differ so sharply with the long-held concept of the mentally ill person as a legal object without many months of educational work done previous to the final passage."

The report is a model of its kind, and it is a temptation to quote freely from its well-formulated statements of the problems that challenge the attention of mental-hygiene societies in these times. We add just one more item because it expresses admirably the aim and spirit that should animate organized mental-health work in the critical period confronting us:

> "We are in an emergency period. As the drive for national defense gains momentum, those factors in our civilization which are less tangible than armaments must be safeguarded and our faith in them kept alive through continuous review of what we hope to have when peace comes again. During the emergency, private societies, such as ours, must work to prevent the breakdown of our existing health services. We must go further and prepare to care for men, women, and children who show mental disabilities developed under actual conditions or under the threat of armed conflict. We shall need to give some attention to the fortifying of the morale and to urge steps to prevent breakdown among those men who are taken away from their established routine by the requirements of the army, navy, and air corps. Even now we are seeing the need for fostering the confidence and morale of their families."

Selection of Personnel in the Field of Social Work *

How and by whom shall the selection be made?

Maud E. Watson, Ph.D.

Director, The Children's Center, Detroit, Michigan

ANY discussion of the selection of personnel in the field of social work brings forth immediately many questions. The field itself, divided as it is into numerous divisions, such as research, group work, social planning, and the more technical work, involving case-workers or technicians, demands intelligent, adequately trained individuals who must of necessity not only understand interpersonal relationships, but also themselves possess well-integrated personalities in order to work effectively.

Shall we confine our discussion this afternoon to the selection of the technical case-worker? In studying the case-worker, we must consider not only his present status, but his future as well. Will he, after several years, become an executive, whose duties will involve being an administrator and an effective interpreter of social work to other professions, to the lay community, and even to the state legislature if necessary, since many of our laws are closely connected with social work?

How shall we select this social worker who is supposedly well grounded in all academic subjects pertaining to his own professional field, with some practical training in his particular interest, at least to the extent of nine months of supervised field work? Should candidates for the schools of social work be so carefully selected before admission that they are no longer considered a risk when it comes to the assignment of a position in the outside world? At once the reply comes that many of the student's personality difficulties do not appear until the second year. With whom, then, if the student is not fitted for social work, does the responsibility lie of persuading him to enter another field? Does the school too often feel that the student has already had two years of preparation and that it is too late for him to change, or that he may grow and develop under further guidance when he is actually at work? To the writer the answer is obvious that the more carefully the student is selected at the time of admission, the fewer difficulties we shall incur as the worker goes on.

How shall this selection be made and by whom?

1. Certainly a thorough physical examination is indicated, not a

* A discussion at a special session arranged by The National Committee for Mental Hygiene at the Sixty-seventh Annual Meeting of the National Conference of Social Work, Grand Rapids, Michigan, May 30, 1940.

mere cursory glance at one who must work many hours a day and carry the burden of those who are physically unfit and emotionally burdened as well. Shall we accept no physical limitations in our workers—for example, cardiac difficulties, physical handicaps such as orthopedic conditions, defective hearing, and so forth? Or does that depend upon the mature or the immature way in which the worker himself accepts his physical limitations and how important the physician and psychiatrist may feel that they are, first as to prognosis and, second, as to how much they may interfere with the effectiveness of the student's work?

2. We ask for intelligence in our social workers. Shall that be measured by high academic attainment in undergraduate college plus the same high intellectual standard in the first year of graduate school? Will that determine real intelligence, or a mere intellectual facility which enables the worker to grasp facts on the written page of a book, with no criticism, but a mere passive acceptance, and to give those facts back to the professor at his will? How will that actually affect the student's practical professional practice? Will he remain cold and unfeeling in his real therapy with people, having always a fine intellectual concept, but no emotional acceptance of this philosophy which he is attempting to interpret to the individuals who are under his treatment? Shall intelligence rather be evaluated by a battery of tests under a good clinical psychologist who has an understanding of emotional conflicts and how devastating they can be in estimating anything but the potential working level of such an individual in a present situation? I believe it is accepted now that conflicts understood and solved often raise the level of intelligence. Is such an examination to be considered alone or together with the physical and psychiatric examinations as only part of the whole picture of the student who is entering social work?

3. Shall the real effectiveness of a personality be determined by the mental hygienist or the psychiatrist? It is my own opinion that a psychiatrist is of unlimited value in the final selection of personnel, provided he is adequately trained in understanding interpersonal relationships and the motivations of his own behavior. He should, of course, also have a wide experience in the observation and treatment of psychotic manifestations. The psychiatrist adds to his evaluation the results of the physical and psychological examinations, and only then do we have a complete insight into a total personality.

We cannot always depend upon the services of a psychiatrist, but we can depend upon the adequately trained psychiatric social worker. She will always look to the psychiatrist for counsel when the student shows symptoms that lie beyond her field—for example, evidences of a pre-psychosis or a deep-seated emotional problem. Often, too, she has the opportunity to work continually under the guidance of a

psychiatrist, which is very important. Well-trained psychiatrists and good psychiatric social workers have no quarrel, only mutual respect for each other's contribution.

What, then, from a mental-hygiene point of view, do we wish to know about this worker who may soon be a part of our organization? What has been his feeling toward his life experiences and how clearly can he see himself as a product of it? What, as a result, is his feeling toward himself and others? Does he dare to feel, or has he covered himself with a shell against the wear and tear of the day, oblivious of his own anxieties, frustrations, hostilities, and repressions, which he must constantly project on others to relieve his own tensions? What will this mechanism do to his clients, who feel that he is walled in, but who cannot verbalize their own feelings of disturbance in the presence of the worker, except to say, "He cannot understand me or I him," or, more tritely, if referring to a woman worker, "She gave me nothing," referring to material things? Or does it refer to material things? I wonder.

Extreme youth and lack of experience in a social worker may make his task doubly hard. The fact that he is just out of college, that he has been reared in a very satisfactory home with high economic standards, may place him at a distinct disadvantage. He is facing many new reality situations daily, situations that he has read about in textbooks, to be sure, but never encountered before as actualities. How often parents dependent upon social-work organizations have said, "I wish I could have an older worker. He is too young." It is not age that they are seeking, but maturity in feeling, which does not permit glib advice or censure, but helpful understanding and an attempt to see the client's personality more clearly step by step. We view with humor the barrage of terms turned against us in case discussions by "fresh young things" just out of schools of social work. They speak with intensity of "dynamic passivity" and "high objectivity" as a part of their technical skills, and tell us in one sentence about the members of a family whose behavior is due entirely to an "Œdipus or to guilt, etc." Little do they know the real value of these terms or how simply the situations can be put if clearly understood.

What has the social worker's real attitude been toward his parents and toward parental authority? Is he still trying to work out his own rebellion, while at work, on his supervisor or executive, whom he has now placed in the rôle of parent? What is his relationship to clients—punishing or "mothering too much," because he is now trying to be a parent? One might go on indefinitely—e.g., into sibling rivalry. What have been the social worker's relationships with his own brothers and sisters in his family? One of undue competition, with considerable jealousy and constant bickering, or, in a more subtle way, with

resentment and deep irritation? Is he still working this through in his relationships with his colleagues or clients who are now the symbols of his own siblings?

One could look further, into the social worker's real feelings with regard to the coming of his brothers and sisters. Did they come too rapidly, with no corresponding increase in the economic level of the family, and did he as a result feel deprived of material things which he felt were his due? It is not uncommon in child-guidance work to-day to see children who have feelings of being crowded and unwanted because of a too quick succession of siblings. If the social worker has had a like experience which he does not thoroughly understand, will he carry over much of his own ambivalence into treatment in a large family toward the mother, father, or the children?

The mental hygienist and the psychiatrist will ever be alert to all these feelings and many more in the social worker whom they observe. What blind areas does he possess in his own feelings—deep resentment toward religious differences, racial prejudice, too much feeling about social status, etc.? Perhaps there should be some discussion also as to the way many workers feel about money, even to their own pay checks. Has this developed out of their life experience and is that at the basis of it?

Another problem that is often seen is the constant shifting of social workers to other positions, driven on by their own inner feelings and motivations. Does the continual changing of positions indicate how deep their real need is and what a good rationalization changing to a new environment may be? Unless the social worker has a pretty complete insight into his own deeper motivations of behavior and feelings, is there a danger that he may have no awareness of hidden mechanisms in his clients?

If we hold to a high standard of performance in the social-work field, shall we select more carefully with a greater insight those who would enter this profession? We are constantly attempting to discover why medical students enter the field of medicine, teachers the field of education, nurses the service of nursing, and so on. Shall we, in a profession that deals always with human relationships, but that because of its many ramifications offers opportunities in addition for interpretation and has much to contribute to medicine, education, nursing, psychiatry, and even to those who will do our social planning, attempt constantly to see more clearly whether or not these young people are fitted for social work at its best or will be merely routine day-by-day case-workers of questionable value? Is the social worker of the future not only one who understands himself and interpersonal relationships adequately, but also one who is critically and flexibly intelligent toward a world that is changing constantly in its reality and in its pressures—economic and social?

THE PERSONALITY OF THE CANDIDATE FOR TRAINING

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DR. WATSON has covered a great deal of territory and I want to limit my discussion to one small part of this. I want to talk about the aspect of the problem that she herself has said is a particular concern of the psychiatrist—that is, the wholesomeness of the personality of the candidate, and I want to talk only about the candidate for training in social work, and not about the young social worker who is a candidate for her first job.

It is obvious that in looking for candidates for training in social work, we are not looking for the finished product. If we were, there would be no point in the schools. We want our social workers to be equipped with the professional techniques, theories, and knowledge which the profession has accumulated, but we don't expect these things in the student entering the school. We all recognize that it is one of the functions of the school to transmit these things to the student.

We also want our young social worker to be reasonably mature, reasonably free from the necessity of exploiting the human relationships which her work involves to the satisfaction of her own immature emotional needs, and reasonably endowed with insight to avoid these dangers, but should we expect this of a student entering the school of social work? I don't know what answer the school would give, and I am glad that Dr. Witmer and Mrs. Cranefield are here to give their points of view. But I am going to venture my own answer. I don't think we should expect any such thing. It seems to me that it is just as much the function of the school, and particularly of the agency in which the student has her field-work training, to provide opportunities for growth and maturing as it is to equip her with intellectual tools. The first is just as much a part of education as the second.

I think it is entirely unreasonable to expect the young college graduate to have the degree of maturity, poise, and insight that we require of the social worker. I have been impressed over and over again in my contacts with young people with the fact that the young adult or post-adolescent, when he has to work in a responsible position involving human relationships, nearly always develops pretty acute anxiety and insecurity. When I began work in a child-guidance clinic after experience in a mental hospital, I was surprised at the extent to which students placed with us for their training were upset. The life stories, and the psychopathology that one dealt with in the child clinic, after

experience in a mental hospital, were so mild, almost normal, that I couldn't see at first what all the shooting was about. I learned to in time.

Then when I went to work in a public-school system, I saw the same thing happen all over again. There, too, we had young college graduates who spent nine months with us in their training for teaching, and these young people, in the course of their experience, also developed acute anxieties and marked insecurity.

And now I am again seeing the same thing happen in an industrial situation. Here, too, our young college graduates placed in supervisory positions and responsible for other people have, in many instances, become decidedly insecure and uncomfortable. And I also have the impression that it is the people who develop insecurity who make the best supervisors in the long run. The person who goes blithely on his way, unconcerned about it, is too obtuse to recognize his fellowship with creatures less fortunate than himself.

The problem, as I see it, is not to find young people who are mature and poised, but to discover those who are most likely to profit by the experience, and thereby to develop insight, poise, and maturity. This is a very difficult thing to recognize. There are just two suggestions that I should like to make.

The first is that I think we should take people who have a real consuming curiosity about other people, people who are able to be astonished and even bewildered at the manifestations of human nature that most people take for granted. This is a quality that all of us in this field need to retain throughout our lives.

The second thing that I should like to suggest may seem barbarous. It is that we should try to select people who are going to discover their own inadequacies and discomforts quite early in the game. One of our problems at the child-guidance clinic was that although we had the students for nine months, it wasn't until late in the spring that they would become sufficiently uncomfortable to seek our help, and then we would have more demands on our time than we could possibly meet, if we were to get them in shape to go back and profit by their summer-school experiences. The same thing was true in the school system, and although again we had the students for nine months, it wasn't until about the first of May that they began seeking me out, and then I had my hands full. In fact, after a year or two, the dean and I used purposely to give these students disquieting material early in the school year in order to get them to me with enough time so that I could do a constructive job.

There are two more general observations that I would like to make about the whole problem of the selection of personnel. The first is

that it is essential for the psychiatrist who is being used for this problem to know intimately the job for which he is helping to select people. A classical scientific diagnosis isn't relevant to the situation, and will be of very little help in guiding people who are responsible for the choice.

The second point I want to make is that important as the selection of personnel is, we want to be careful not to allow ourselves to use this as an alibi for an inadequate job of supervision. We want to get the best material available, but we want also to remember that human nature is never up to specifications. None of us are exactly qualified for the jobs we are called upon to do, and it is the responsibility of the supervisor to get the job done with the imperfect material with which he has to work.

SELECTING THE APPLICANT FOR ADMISSION TO A SCHOOL OF SOCIAL WORK

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DR. WATSON has put so many questions to us that it leaves me a little dazed. I am not even quite sure whether we are discussing the question of selection of students for entering a school of social work or for graduating from it, or whether the problem is the selection of personnel for an agency's staff. Since, however, the only reason I can see why I am included in this panel is because I represent a school, I shall confine my remarks to that side of the question. Then, since there is probably more dispute as to how to select students for entrance than for graduation, I shall further limit myself to what might be called the question of intake.

This is a problem that school administrators have discussed for years and they can cite case after case in which a candidate who seemed unpromising, especially from the point of view of mental health, became a competent case-worker. (They have, however, never counted up how many such people failed to do good work.) They will also tell you of the difficulty of judging maturity, stability, and capacity for being of help to clients when the applicant for admission to a school is a young, untried person of narrow life experience. Nor have they much faith in psychiatrists' abilities to judge the potentialities of prospective students, for they have found that psychiatrists are so accustomed to being therapists, with their patients' interests at heart, that they are apt to think more of what the student will get out of training than of what she will contribute to the profession.

In spite of all this, however, I do not think that the selection of students is hopeless. But I am sure that if it is to be done successfully, it will have to be entrusted to people who are especially equipped by personality and training to undertake it. It is a highly specialized task for which much research is needed. This should consist of keeping careful records of observations of the applicant, the basis for the decisions reached, and of the student's subsequent progress in the school and later. Such research can be carried on, however, only when very professionally competent people are in charge of passing upon applications.

For the most part, I think that the persons in charge of a school's intake should be skilled and unusually intelligent and sensitive psychiatric case-workers who are also teachers or supervisors of case-work. From such people we may expect an understanding of what qualities of personality are particularly important in case-work, an ability to recognize in others the presence of such qualities or their potential development, and an ingenuity in setting situations in which applicants will reveal these professionally important qualities in a single interview.

Not to put the whole responsibility for selection on to these ideal intake workers, I would also add my personal conviction that case-workers need intelligence as well as the ability to feel deeply. This need becomes increasingly apparent as case-work slowly develops into a self-conscious, responsible profession. Leaders in case-work thinking are woefully lacking to-day, and in addition there is a deplorable tendency within the profession to rush sheeplike after each new person who has a new word for some old concept. Case-work can become a real profession only when it builds up a body of practice that is securely rooted in well-understood theory. To develop such a body of theory requires of case-work leaders the highest intelligence, and to comprehend the theory, and so understandingly to use, criticize, and advance it, demands that the students also have "brains."

THE QUESTION OF MOTIVATION

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DR. WATSON set the tone of the meeting when she began by raising a series of questions. She has shown an experienced awareness of the nature of the difficulties that confront young workers entering the field of social work, and has suggested through her questions many of the significant areas of experience that will help

determine whether or not a given candidate for case-work practice is suited to the field. Yet by the very character of her approach—through the question method—she has defined the state of our thinking in relation to this problem. She has asked us to explore together.

It seems to me that we need to orient our thinking in terms of four or five questions:

1. *What basic equipment* does one entering the field of social work need? Dr. Watson has suggested a number of things—an adequate physical make up, an intelligence much better than average,[1] an emotional orientation that makes it possible, first, to assimilate the available knowledge of human behavior, and, second, to use one's trained or professionalized self in constructive service to others.

In attempting to determine this last element, still nebulous in our thinking, we find ourselves turning to the second question:

2. *Why* has this person chosen the field of social case-work?

Those of us who have shared in the responsibility of selecting students for admission to graduate schools of social work have met this response over and over, "I want to go into the psychiatric case-work field."

"So? What does the psychiatric case-work field mean to you?"

Answers are often vague, but the general response indicates that interest in working with the emotional elements of people-in-trouble is the aim. Often a conviction is expressed that because the candidate has known the intensity of such problems in his own development, he wishes to help others to establish satisfactory balances. Sometimes this points to satisfaction in economic relationships, sometimes to vocational or work relationships. Sometimes it points more clearly to the interpersonal family relationships—parental, marital, and so on. Almost always it points to his own most troubled area.

Now this comes to be one of the most significant points of our exploration. I have known both agency and school representatives who regard it as a universal danger signal. "Look out for people who come into the field because of their own personal problems." There is something in that, to be sure, but before we discourage a candidate, let us try to determine the answers to our three last questions:

3. *To what degree* does his personal need to work out his own problems motivate him?

4. What is the depth of those problems?

5. What is the general trend in his reaction to his problems? How has he handled his own life experience?

He may be right—because he has felt much conflict, he may be more

[1] Dr. Edith Abbott has amply presented the many fields necessary to an understanding of the profession in her *Professional Training for Social Work*. To master the basic materials requires intelligence of a high order.

sensitive and helpful to others, provided he has achieved some understanding of himself, or provided it appears that with proper training he may arrive at such an understanding. I have often thought that none of us would ever choose a field like this, where day in and day out we walk in the shadows of other people's troubles, if we were not fundamentally interested in the study of shadows through our own experiences. The *desire* to help is rooted more often than not in our own first-hand experience with trouble. The *ability* to help, following upon the desire, is another thing again.

Dr. Watson has suggested that several skills and disciplines should combine to evaluate the potentialities of a given person—the medical man, the psychologist, the social worker, and the psychiatrist. She hopes that it will then be possible to arrive at a reasonable estimate. (I say "hopes" because no one of these experts, nor any coalition cabinet of *all* of them, have in my experience claimed to be *sure* of their findings, because of the complex character of the factors they seek to study.)

The difficulties in the way of our best interviewing skills are repeatedly illustrated in the experiences of all of us. We know very well, for instance, that all the while the interviewer is trying to determine the subtle meanings of the applicant, the applicant is very busy trying to determine the meanings and values of the interviewer, and hoping to "give the *right* answers." This in itself may become apparent—but who is to deny that there is much reality, much good sense in this approach by the candidate?

Recently a student of some maturity was making application for a scholarship in the psychiatric case-work field. He was requested to fill out a questionnaire which asked among other things (1) why he had entered the field of social work, (2) what his interests had been in recreational lines—suggesting a number of types of activities, (3) a delineation of some experience he had had in which he had been helpful to another. He asked for a consultation in regard to it.

"It is impossible to say completely *why* I came into social work," he said. "I don't know. A year ago, before I had any courses in case-work and mental hygiene, the answer would have been easy. I wanted to get away from the industrial field—my interest was in people—the social agencies were hiring. Now I know that in addition there were many things bothering me which I kept trying to work out by getting into what other people felt and did. If I say that on my questionnaire, I'm sunk, I suppose.

"And look at this—I like to read—to travel—I enjoy the theater. All of those *were* escapes—I know that now. Parties bored me. I know now that I couldn't relate myself too easily to a group and that goes back to the 'gang' at home and all that meant. I did enjoy a few

friends, but they were attachments of long standing. I haven't one thing to say that will give this other side of myself that I'm finding so satisfactory."

I raised the question as to why he wasn't considering answering in the way he thought would make him appear social—even gregarious. It had never occurred to him to falsify (though it has to many another).

"*I* have an interest in this, too," was his answer. "I don't seem to want to hide out on myself. Seems I've only begun to learn what it's all about—and that's good." He was speaking easily, with some humor at his dilemma, but with conviction.

The field-work experience of the past semester had indicated a warm relationship with people and a growing competence in the field. He knew, too, that performance had been satisfactory. My guess was, that having discovered many unexpected aspects of himself, he was a little uneasy as to what additional things he would find, how *he* would react to them, and how others would react. A natural enough reaction of protection—and I suspect common enough.

Others have expressed a need to protect themselves from revelation to the interviewer, who they expect will say "yes" or "no" depending upon the presentation of self they make. Some of them are not so sure they trust us on first acquaintance. Again—*could* it be that they are right at times? We who help select students have been known to lack complete self-understanding, to accept or reject because of our subjective realities.

Dr. Watson touched lightly upon the reasons for our great concern over this process of selection of personnel, but perhaps she will be able to endure repetition for emphasis.

Behind all this careful choice of personnel lies the responsibility toward a large group of people whom we call clients. We have learned much about the ways in which we have hurt more than we have helped in the past. We know that the reason for this has often been found within the person who sets out to help. At least in those areas in which we *recognize* the reasons for such circumstances—*i.e.*, hurting more than we help—we must guard against them in the future. For the moment I am ignoring the question of all the people who have come into the field at times of mass need—or who come through merit systems, still inadequately standardized.

In the second place, we carry a responsibility to the potential social worker. While a few of us go on happily year in and year out running other people's lives, punishing and rewarding (in both often equally destructive to the client), all out of our own needs, most workers who fail to give service go about unhappily—at least partially aware that they are failing to do what they set out to do. Super-

visory criticism, agency dismissal, many miserable consequences appear to push them deeper into a sense of inadequacy. The longer this continues, the more disturbing it becomes. When a student takes upon himself the uphill climb of two years' graduate work (energy consuming, finance expending!) we owe it to him to help him explore himself and his place in the field. We have long since agreed that we owe the client help in determining whether or not he wishes to continue with case-work service. Long overdue is a similar acceptance of giving all we have to help the student think through whether or not he wishes to undergo our particular kind of training.

Dr. Watson spoke of how difficult it was—once a student had spent time and effort, possibly going into debt—to go through the process of redefinition of his proper vocational field. Well, that's hard—but no harder than helping him think his way through when first he comes to us. At this state of our understanding we sit less as judges than we do as leaders in a mutual exploration with the student. My student—the one I mentioned who needed to watch his every expression lest he be misjudged—said, "I have a share in this, too!" Of course he had a share in it. But he was arriving at that point almost as if it were *extraordinary* and of no concern to the Powers who were to say, "Thou shalt—or thou shalt not," those judges who somehow were trapping him into self-revelation without giving him the benefit of revealing how they were using his material. Certainly in the development of our skills in choosing and judging, we must also develop our own complete acceptance of the whole process as a *shared* quest. This, too, is a part of the long process of "giving a hand" in the growth of the student or worker.

New Publications

Insight is the meaningful title of a new publication issued monthly by the Wender Welfare League, Inc., the society of former patients of the Hillside Hospital of New York. Pioneering in the important and growing movement, launched and largely activated by laymen, to divest mental disorders of the unjustified stigma with which they are still associated in the public mind, and to spread correct notions and attitudes in the field of mental health, the enlightened and courageous group sponsoring this sprightly and instructive popular periodical is worthy of all praise.

Thanks to the splendid efforts of this and similar organizations formed for the purpose of educating public opinion to a better understanding of the mental-health problem, the time is fast approaching when sick minds will receive the same intelligent attention as sick bodies, and the obscurantism and ignorance, false shame and reticence

attending this phase of medicine and public health will be things of the past. We commend to those struggling against hampering prejudice and superstition in this field the brave "Credo" promulgated by the former patients of Hillside Hospital in the November issue of *Insight,* which is edited by Dr. J. H. Friedman. Correspondence relating to the publication should be addressed to Dr. Friedman at 1749 Grand Concourse, Bronx, New York City.

Students of legislative and social measures to combat mental disease and mental defect, whatever their attitude toward some of the more controversial aspects of state programs for mental health, will welcome the new study on eugenic sterilization in the United States, made by James E. Hughes, of the Division of Mental Hygiene of the United States Public Health Service, and just published as Supplement No. 162 to the Public Health Reports. The report, a forty-five-page document, gives a comparative summary of statutes and a review of court decisions, and brings the record of legislative and judicial action in respect to sterilization in the various states down to date. It contains also a selected list of references to the general literature on sterilization, published from 1914 to 1938, and a list of articles in legal periodicals dating from 1897. Copies may be secured from the Superintendent of Documents, Washington, D. C. (Price 10 cents.)

A very readable and valuable pamphlet, *The Retarded Child at Home,* prepared by Katherine G. Ecob, Executive Secretary of the New York State Committee on Mental Hygiene, brings together specific practical suggestions about the care of the mentally retarded outside the institution. The subject matter of the pamphlet ranges from an explanation of the nature, causes, and extent of retardation, to school placement, employment and home care, and the relation of retardation to delinquency, personality development, and mental hygiene. The material is designed to assist nurses, social workers, teachers, and all who are faced with everyday problems in the guidance of mentally retarded children and their families. Single copies are available (at 20 cents) from the New York State Committee at 105 East 22nd Street, New York City.

ORTHOPSYCHIATRIC GROUP TO MEET IN NEW YORK IN FEBRUARY

Dr. Norvelle C. LaMar, Secretary of the American Orthopsychiatric Association, announces that the organization will hold its Eighteenth Annual Meeting at the Hotel Pennsylvania, New York City, on February 20–22. A preliminary program will be sent on request. Inquiries should be addressed to the association at 1790 Broadway, New York City.

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DIRECTORY OF STATE SOCIETIES AND COMMITTEES FOR MENTAL HYGIENE

(With date of organization)

Alabama Society for Mental Hygiene (1915)
Miss Katherine Vickery, Secretary
Alabama College, Montevallo

Northern California Society for Mental Hygiene (1937)
Mrs. Susan Richards, Secretary
45 Second Street, San Francisco

Southern California Society for Mental Hygiene (1923)
Dr. Oscar Reiss, Secretary
1325 W. Adams Boulevard, Los Angeles

Connecticut Society for Mental Hygiene (1908)
Dr. George K. Pratt, Medical Director
152 Temple Street, New Haven

Delaware Society for Mental Hygiene (1932)
H. Edmund Bullis, Executive Director
911 Delaware Ave., Wilmington

Illinois Society for Mental Hygiene (1909)
Dr. John Chornyak, Director
343 S. Dearborn Street, Chicago

Indiana Society for Mental Hygiene (1916)
Thurman A. Gottschalk, Secretary
141 S. Meridian Street, Indianapolis

Kansas Mental Hygiene Society (1920)
Miss Melba Hoffman, Secretary
1525 N. Vassar Street, Wichita

(Kentucky) Louisville Society for Mental Hygiene (1921)
Miss Ruth Mellor, Executive Director
610 South Floyd Street, Louisville

Louisiana State Society for Mental Hygiene
Paul C. Young, Executive Secretary
Louisiana State University, University

Maine Teachers Mental Hygiene Association (1940)
Charles A. Dickinson, Secretary-Treasurer
University of Maine, Orono

Maryland Mental Hygiene Society (1913)
Dr. Ralph P. Truitt, Executive Secretary
601 W. Lombard Street, Baltimore

Massachusetts Society for Mental Hygiene (1913)
Dr. Henry B. Elkind, Medical Director
3 Joy Street, Boston

Michigan Society for Mental Hygiene (1936)
Harold G. Webster, Executive Secretary
1215 Francis Palms Building, Detroit

Minnesota Mental Hygiene Society (1939)
Miss Elizabeth Glynn, Secretary
216 Citizens Aid Building, Minneapolis

Missouri Association for Mental Hygiene (1936)
Mrs. Helen H. Sala, Executive Secretary
415 West Broadway, Columbia

New Jersey Mental Hygiene Association (1940)
Mrs. Florence H. Staniels, Secretary
Lincoln School, Nutley

New York State Committee on Mental Hygiene of the State Charities Aid Association (1910)
Miss Katherine G. Ecob, Executive Secretary
105 East 22nd Street, New York City

North Carolina Mental Hygiene Society (1936)
Dr. W. D. Perry, Secretary
University of North Carolina, Chapel Hill

Central Oklahoma Society for Mental Hygiene (1933)
Dr. James J. Gable, Secretary
Norman

Oregon Mental Hygiene Society (1932)
Robert Lang, Executive Secretary
608 Pittock Block, Portland

Pennsylvania Mental Hygiene Committee of the Public Charities Association (1913)
Dr. Appleton H. Pierce, Director
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Rhode Island Society for Mental Hygiene (1916)
Miss Helen M. White, Secretary
100 North Main Street, Providence

Texas Society for Mental Hygiene (1934)
Miss Evelyn M. Carrington, Secretary
Box 223, Huntsville

Utah Society for Mental Hygiene (1927)
Walter C. Neville, Secretary
Weber College, Ogden

Vermont Society for Mental Hygiene (1940)
Rev. Gerald R. Fitzpatrick, Secretary
Montpelier

Virginia Mental Hygiene Society (1937)
Mrs. Donna Banting Bemiss, Secretary
1200 East Clay Street, Richmond

Washington Society for Mental Hygiene (1928)
Mrs. Helen Gibson Hogue, Executive Secretary
1502 Textile Tower, Seattle

Wisconsin Society for Mental Hygiene (1930)
Miss Esther H. DeWeerdt, Executive Secretary
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